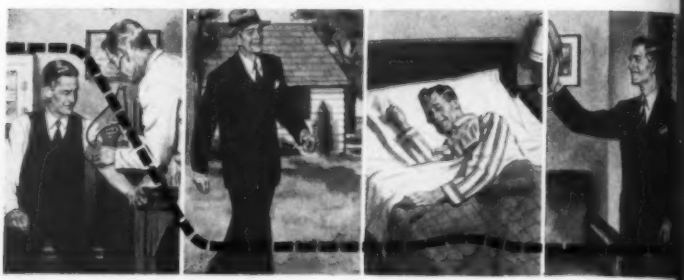
September **Medical Economics**

How About a Business On the Side? • *Page 80*

Isn't this the picture you want to prescribe for your hypertensive patients?



Nitranitol's safe, gradual, prolonged vasodilation permits hypertensives to resume more normal lives.

And . . . therapeutic dosages of NITRANITOL can be maintained over long periods of time . . . *without* frequent checkups . . . *without* worry about possible toxic effects.

Nitranitol is the universally prescribed drug in the management of essential hypertension.

NITRANITOL®

(brand of mannitol hexanitrate)

FOR SAFE, GRADUAL, PROLONGED VASODILATION

1. **When vasodilation alone is indicated**—*NITRANITOL*
2. **When sedation is desired**—*NITRANITOL with PHENOBARBITAL.*
3. **For extra protection against hazards of capillary fragility**—*NITRANITOL with PHENOBARBITAL and RUTIN.*
4. **When the threat of cardiac failure exists**—*NITRANITOL with PHENOBARBITAL and THEOPHYLLINE.*
5. **For refractory cases of hypertension**—*NITRANITOL P.V. (Nitranitol, Phenobarbital, Veratrum Alkaloids*)*

*allowed

Medical Economics

* * * *September 1952* * * *

[CONTINUED ON FOLLOWING PAGE]

Contents [*Continued*]

DEPARTMENTS

CCA

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no need to fight both
allergy and **drowsiness...**

The allergic patient is miserable enough without having to risk the discomfort—and hazards—of drowsiness. When patients take Thephorin, a *different* antihistamine, they usually obtain gratifying relief and remain wide awake. Clinical studies show that four out of five hay fever sufferers obtain relief with Thephorin; yet drowsiness occurs in less than 3 percent of patients. Thephorin is particularly valuable for motorists, machine operators and other patients who must be alert. Available in 25-mg tablets and as an anise-flavored syrup, containing 10 mg per teaspoonful.

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Thephorin®

(brand of phenindamine—2-methyl-9-phenyl-2,3,4,9-tetrahydro-1-pyridindene hydrogen tartrate)

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MAKE YOUR FLUOROSCOPY EASIER

WITH THE **PEDAFLEX*** FOOTSWITCH

When both hands are occupied, the PEDAFLEX footswi allows full control of room lights and X-rays

Here is an efficient footswitch with clean, slender lines which hide a ruggedness designed to take heavy punishment.

The Pedaflex is "skate-proof", exceptionally thin in section and lies comfortably underfoot.

It offers positive control in opera while standing or sitting. A lumines tracer spot guards against accidental tact in darkened rooms. And, the f switch can be used with all main X-ray equipment.

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YOU CAN BE **SURE**...IF IT'S

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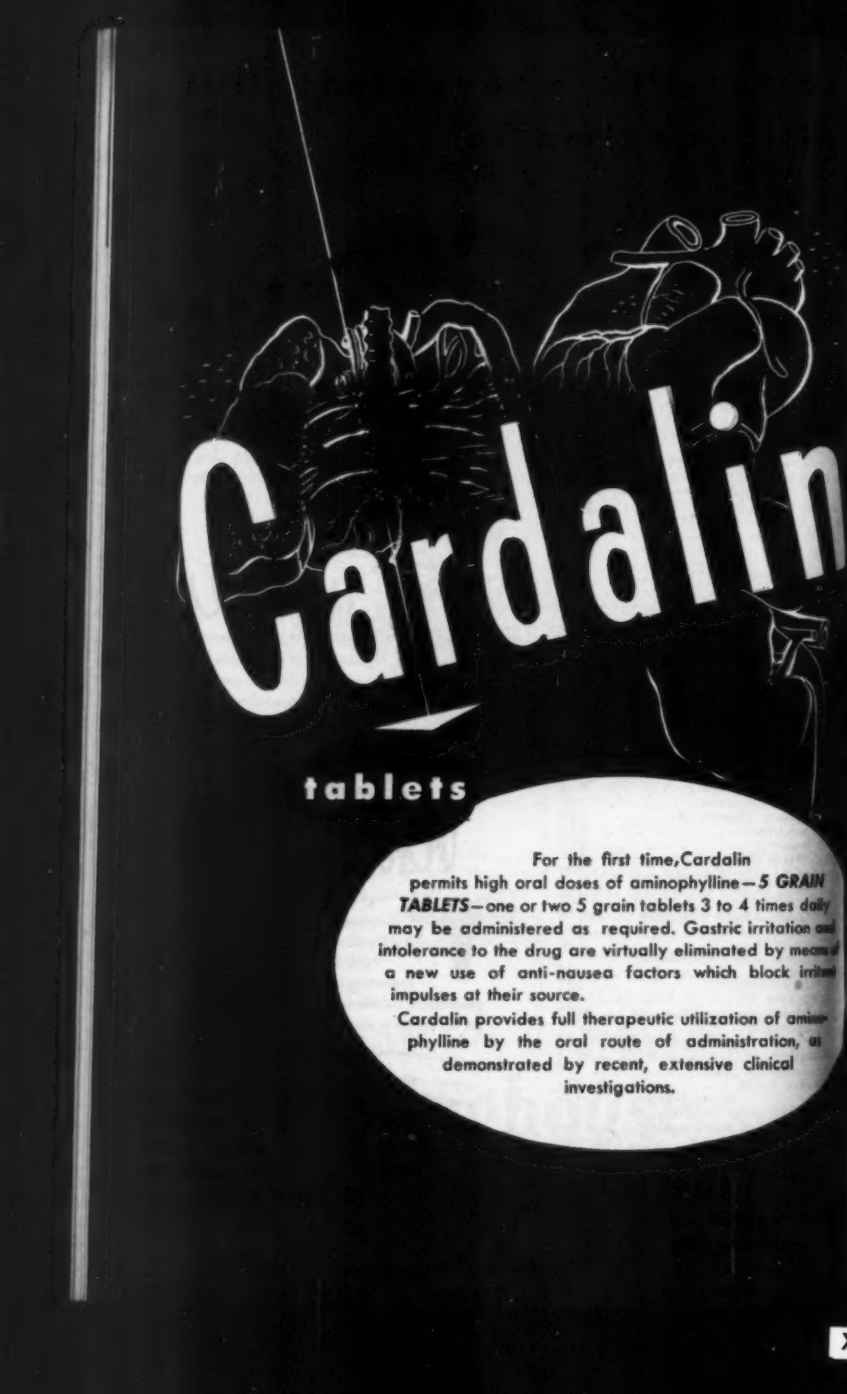
MEDICAL X-

Index of Advertisers *

* In Specified Territory


Cardalin
tablets
For the first time, Cardalin permits high oral doses of aminophylline—5 GRAIN TABLETS—one or two 5 grain tablets 3 to 4 times daily may be administered as required. Gastric irritation and intolerance to the drug are virtually eliminated by means of a new use of anti-nausea factors which block irritant impulses at their source.
Cardalin provides full therapeutic utilization of aminophylline by the oral route of administration, as demonstrated by recent, extensive clinical investigations.

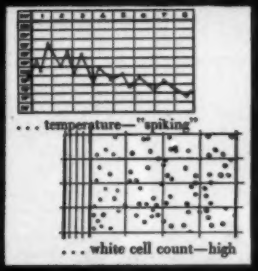
URINARY TRACT

Pyelonephritis

Pyelonephritis occurs most often in the young child . . .

commonest in the "diaper-age" female

The onset is sudden, usually with a chill . . .



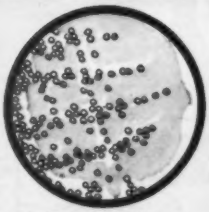
. . . temperature—"spiking"

. . . white cell count—high

Always, pus cells and bacteria appear in the urine

look for *clumps* of white cells in *catheterized* specimens

Culture determines pathogen. Mixed infection not uncommon.



in 8 out of 10 children, colon bacillus invades

Sometimes there is tenderness over the kidney region . . .

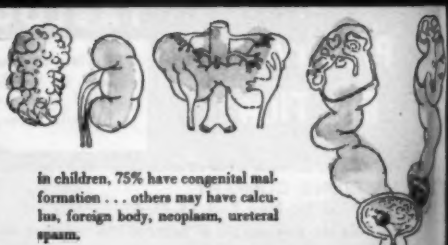
try the McKnight punch, or

palpation in CVA

. . . or abdominal pain and rigidity

suggestive of an acute abdomen

Look for a cause of urinary stasis.



in children, 75% have congenital malformation . . . others may have calculus, foreign body, neoplasm, ureteral spasm.

Panorama

Wanted: 900,000 doctors. There are now about that many in the world, but the number should be doubled to meet even minimum health standards, says a United Nations report . . . Until osteopaths can prove their theories, they'll remain medical outsiders, says President Floyd Peckham of the American Osteopathic Association . . . Is financial acumen an inherited characteristic? Probably not, thinks Surgeon Robert U. Cooper, who papered part of his Washington, D.C., home with worthless stocks inherited from his father, then authored a book of investment advice for doctors.

Last year, Los Angeles Dentist C. H. Blanchard went home from a Seattle dental conference with a broken nose—the result of an over-ardent good-by kiss from the local dentists' executive secretary. Now they are married . . . Proposed medical centers for low-income families in New York City's state-aided housing projects won't compete, it's claimed, with private physicians. So Manhattan doctors have agreed to try them out. They will be staffed and run by local hospitals . . . There are plenty of registered nurses, but too few *active* ones, reports the American Nurses' Association. It finds that only about 335,000 out of a total of nearly 560,000 U.S. nurses are actively engaged in nursing.

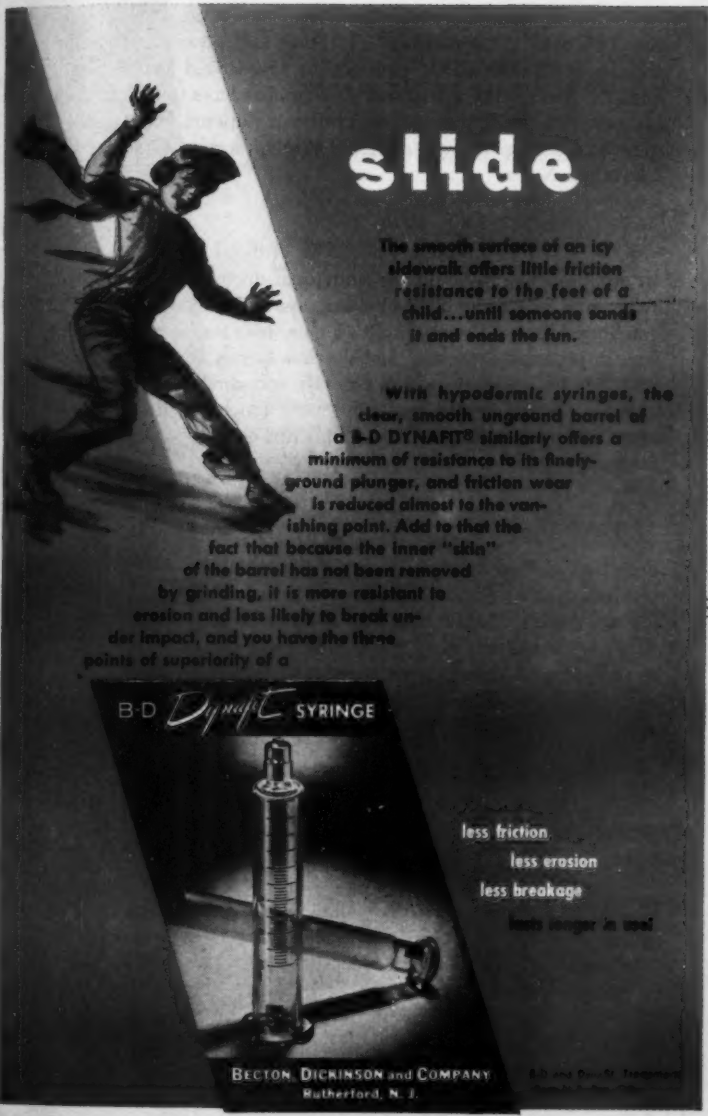
Looking for some expert advice in planning or reorganizing a hospital? You'll find the names of thirty-three leading hospital consultants, along with background information about each, in a directory compiled recently by the American Hospital Association . . . Consulted by a bride whose honeymoon was being spoiled by a severe earache, Dr. John H. Wilson of Magnolia, Ark., quickly found and removed the cause: a grain of rice hurled by an overenthusiastic wedding guest . . . Health

insurance is partly to blame for the hospital-bed shortage, says Dr. James Lightbody, in the Detroit Medical News. Reason: Once-hesitant patients now want hospitalization for even minor illnesses. "If somebody yelled 'Fire!' in any general hospital today," he adds, "90 per cent of the patients would be quite capable of walking out."

Double-dyed doctor who faces a lifetime of bad jokes was graduated this year from New York Medical College. His name: Daniel Doctor . . . To forestall charges of discrimination or "politics," Long Island's new North Shore Hospital has asked 446 local physicians to apply for top staff jobs, and has named an impartial panel of New York M.D.'s to help select the best candidates . . . Malpractice prophylaxis: "Never express doubt to a patient concerning the wisdom of your treatment." So advises a booklet issued by the Colorado State Medical Society, which then urges doctors to avoid lawsuits by following the old judicial rule: "Render your verdict but do not discuss your reasons for it."

Telling a new physician that your community doesn't have a fee schedule is like "telling him to do as he pleases regarding fees," says President Sobisca S. Hall of the West Virginia State Medical Association. He urges all county societies to formulate fee schedules . . . Cab driver James K. Gordon, of Washington, D.C., not only paid his way through medical school with the fares he collected but paid for his taxi too. As a graduation present, the cab company painted the new doctor's quondam taxi a dignified gray—suitable for house calls.

Incensed at the length of his wife's hospital sojourn, a Dallas, Tex., man started a habeas corpus action against her doctor, charging that she was held a hostage for an unpaid $192 bill. Meanwhile, she was released; so the judge dismissed the case . . . Closer teamwork among New York physicians and social workers is expected now that the state has coordinated numerous medical activities of its welfare and health departments. The aim: to improve medical services for public-aid recipients at the lowest possible cost . . . Political Rx: A "wonder drug," invented by the New Jersey Taxpayers Association, is alleged to


slide
The smooth surface of an icy sidewalk offers little friction resistance to the feet of a child...until someone sands it and ends the fun.
With hypodermic syringes, the clear, smooth unground barrel of a B-D DYNAFIT® similarly offers a minimum of resistance to its finely-ground plunger, and friction wear is reduced almost to the vanishing point. Add to that the fact that because the inner "skin" of the barrel has not been removed by grinding, it is more resistant to erosion and less likely to break under impact, and you have the three points of superiority of a
B-D Dynafit SYRINGE
less friction
less erosion
less breakage
lasts longer in use
BECTON, DICKINSON and COMPANY
Rutherford, N. J.

cure "the fiscal ills of government" and ease "the pain of taxation." Its name: "Economycin" . . . Some G.P.'s sweat out public tributes at "Doctor's Day" doings, but 91-year-old Dr. Abraham Lincoln Tinstman of Cleveland, Ohio, didn't have to budge from his sick bed. Five pictures of Tinstman patients, each with a glowing testimonial, were scattered through a recent issue of the Cleveland News.

Carte blanche for artificial insemination: It's an accepted therapy, and the individual doctor may resort to it "when and where and if" he chooses, says the council of the Michigan State Medical Society . . . It's a good idea for doctors' aides to have an occasional meeting, just like their bosses, says the Vermont State Medical Society, which recently sponsored a one-day get-together for the secretaries. Along with luncheon, the aides get some advice on patient relations, plus tips on nursing and clerical duties.

Are the best Blue Cross prospects flat on their backs? Finding that one out of three hospital patients is uninsured, the Cleveland, Ohio, Blue Cross plan has set about signing up these non-subscribers as soon as they're discharged. At that time, it believes, they ought to be good risks . . . May a clinic or individual doctor sponsor an athletic team whose players display the sponsor's name on their shirts? Decidedly not; it's unethical advertising, warns the Michigan State Medical Society . . . Communist criticizes socialized medicine: Doctors in Czechoslovakia are "enriching themselves by means of the health service" and encouraging malingering patients, complains Red Premier Zapotocky.

Even if civil defense is never put to the test, it has turned up a lot of newly qualified first-aiders, says the Civil Defense Administration. In nine months last year, nearly 1 million volunteers were trained by the Red Cross . . . Meanwhile, Civil Defense Administrator Millard Caldwell figures that atomic attack on the U.S. could produce 7½ million casualties, with 5 million surviving the first twenty-four hours. C.D. supplies and equipment are "nowhere near ready," he warns.

You cannot depend regularly on the Vitamin C content of home-squeezed orange juice, but

you can <u>always</u> depend on the Vitamin C content of BIB ORANGE JUICE FOR BABIES

Recognized medical research[1] has revealed variations in Vitamin C content of oranges. Geographic location, varieties and root stock differences, picking dates, distance of shipment eliminate any possibility of baby receiving *consistent* Vitamin C content from specified daily feeding of home-squeezed juice.

BIB Orange Juice *guarantees* its Vitamin C content — over 40 mg/100 cc when packed. This is made possible only by careful scientific selection of fruit, by special processing and laboratory analysis of every batch packed.

All 3 BIB Juices are specially processed to maintain the nutrients for which you include them in the pediatric dietary. Easy for mother to serve; their peel-oil content reduced to a negligible trace, they are easy for baby to digest, as well.

For complete information, write to:
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P. O. Box 866, Dept. LLS, Lakeland, Florida

1. Holmes, Pigott, and Tripp: *New England J. Med.* Beachem and Bonney: *J. Assn. Off. Agric. Chem.* Harding, Winston, and Fisher: Proc. *Am. Soc. Hort.*

BiB juices for babies—juices only!

Mucilose

HIGHLY PURIFIED HEMICELLULOSE OF PSYLLIUM

FIVE DOSAGE FORMS FOR FLEXIBILITY IN PRESCRIBING

1. **Mucilose Granules Special Formula** (with dextrose), tins of 4 oz. and 1 lb. Pleasant tasting, crunchy granules.
2. **Mucilose Flakes Special Formula** (with dextrose), tins of 4 oz. and 1 lb. Pleasant tasting, easily dispersed in water or other liquids.
3. **Mucilose Flakes Concentrated**, tins of 4 oz. and 1 lb. Sugar free (noncaloric), especially useful for the management of constipation in the diabetic and obese patient.
4. **Mucilose Compound Tablets**, bottles of 100 and 1000. Mucilose with methylcellulose. Easy to swallow, convenient to carry.
5. **Mucilose with Cascara Granules**, tins of 4 oz. Contain 1 grain of powdered cascara per heaping teaspoonful (5 Gm.). Particularly valuable during transitional treatment of confirmed users of strong laxatives.

"...the important problem of **constipation"**
in the management of the irritable colon
should not be overlooked.
"It is imperative that the patient stop taking laxatives."
"The routine use of a hydrophilic colloid
such as... **Mucilose**... is often gratifying, and
never contraindicated in irritable colon syndrome,
even with **diarrhea."**[1]

Mucilose

—produces bland peristalsis-stimulating bulk. Through its tremendous water-binding capacity (absorbing 50 times its own weight in water[2]) Mucilose holds its "bound water" during passage through the bowel producing soft, demulcent stools. Conversely, when taken with smaller amounts of water, Mucilose restores the normal water balance in the diarrheal phase of colitis by binding loose stool and reestablishing normal fecal colloid.

Mucilose should be taken with 1 or 2 glasses of water.

1. Straughn, R. A.: *Jackson Clin. Bull.*, 13:83, Aug., 1951.
2. Gray, Horace, and Tainter, M. L.: *Am. Jour. Digest. Dis.*, 8:130, Apr., 1941.

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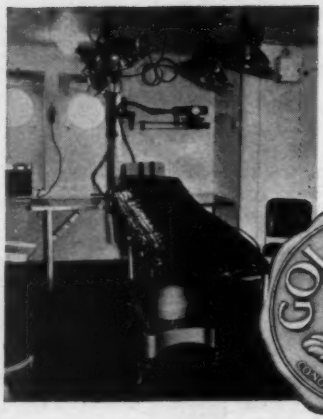

WHY the safest ship afloat uses GOLD SEAL NAIRN STATIC-CONDUCTIVE LINOLEUM!

The great 990-foot luxury superliner "United States" has been built to the *safest* specifications in marine history. Every last square inch of floor covering throughout her dispensaries and operating room is Gold Seal Nairn ® Static-Conductive Linoleum!

Static-Conductive was used because of its unusual property of *dissipating static electricity* which would otherwise present an explosion hazard . . . because of its *durability* and *wear-resistance* . . . because of its *resilience* . . . because of its *slip resistant surface* that's *sanitary* and *easy to maintain.*

Static-Conductive Linoleum is backed by the Gold Seal guarantee of complete satisfaction.

Get complete specifications from Contract Sales Division.

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GOLD SEAL ASPHALT TILE

GOLD SEAL VINYL INLAIDS

GOLD SEAL NAIRN INLAID LIN

stirred up a hornet's nest lately?

It's bad enough to be the unwilling host to a swarm of pugnacious wasps without aggravating them into action.

And in the treatment of most dermatologic conditions, too, it is important not to "stir up the hornet's nest" by the use of an irritating soap that further aggravates the inflamed area and retards therapeutic response.

The choice of pure, mild MAZON Soap assures cleansing action without irritation, and effectively prepares the skin for the antiseptic, antipruritic, antiparasitic action of MAZON.

For more than a quarter of a century, physicians have used this dual therapy in acute and chronic psoriasis, eczema, alopecia, ringworm, athlete's foot, and other skin conditions not caused by or associated with systemic or metabolic disturbances.

Mazon is greaseless . . . requires no bandaging; apply just enough to be rubbed in, leaving none on the skin.

MAZON

at all pharmacies

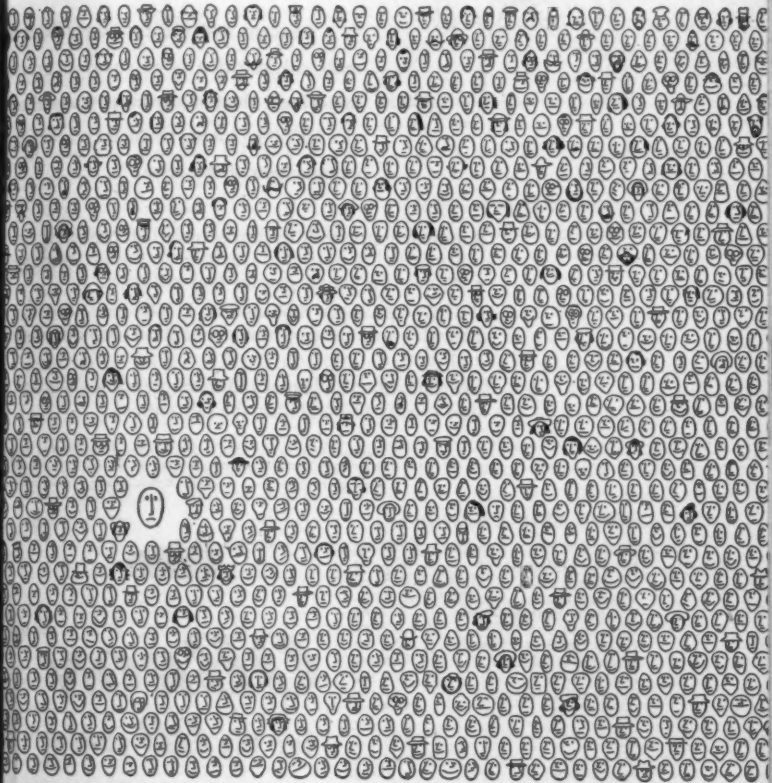
Belmont Laboratories

Philadelphia, Pa.

With a typical "-caine" type topical anesthetic ointment[1], you can expect *one case of sensitivity for every 12 patients.*

With 'Quotane', S.K.F.'s new topical anesthetic, the initial clinical studies revealed not only more pronounced antipruritic activity but only 2 instances of sensitivity in 3000 cases—in other words,

only one case of sensitivity for every 1500 patients.



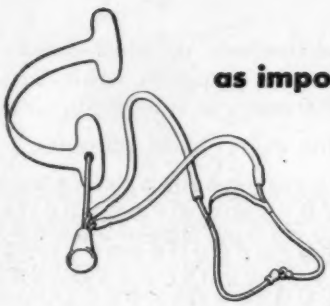
Quotane* Ointment
for dry lesions

'Quotane' Lotion
for moist lesions

Smith, Kline & French Laboratories, Philadelphia

...l Lancet 70:266

*T.M. Reg. U.S. Pat. Off.



as important as auscultation of the fetal heart

"... frequent and accurate supervision ... maternal nutrition is of equal or great importance than of any other prenatal service including taking the blood pressure ... examination of the urine."[1]

Simonnet[2] stresses the importance of providing adequate nutrient in its optimum quantity to assure nutritional adequacy during pregnancy and lactation.

OBRON provides 8 Vitamins, 11 Minerals, and Trace Elements to assure optimum nutrition for both mother and fetus.

For nutritional adequacy during pregnancy and lactation specify OBRON for the OB patient.

1. Tompkins, W. T., cited by Allen, E. D.: The Increased Demands of the Maternal Organism by Pregnancy; Chicago M. Soc. Bull. 52:832 (Apr. 8) 1950, p. 1.
2. Simonnet, H.: Nutrition in Pregnancy; Canad. M. A. J. 58:556 (June) 1948.

....all in One Capsule

Dicalcium Phos. Anhydrous*	768 mg.
Ferrous Sulfate U.S.P.	64.8 mg.
Vitamin A	5,000 U.S.P. Units
Vitamin D	400 U.S.P. Units
Thiamine Hydrochloride	2 mg.
Riboflavin	2 mg.
Pyridoxine Hyrochloride	0.5 mg.
Ascorbic Acid	37.5 mg.
Niacinamide	20.0 mg.
Calcium Pantothenate	3.0 mg.
Cobalt	0.033 mg.
Copper	0.33 mg.
Iodine	0.05 mg.
Manganese	0.33 mg.
Magnesium	1.0 mg.
Molybdenum	0.07 mg.
Potassium	1.7 mg.
Zinc	0.4 mg.

*Equivalent to 15 gr. Dicalcium Phosphate Dihydrate.

OBRON

for the *OB* patient

Available at all Pharmacies

J. B. ROERIG AND COMPANY, 536 LAKE SHORE DRIVE, CHICAGO 11, ILL.

Speaking Frankly

Lower the Bars?

SIRS: Several recent Newsvane items have reported one state after another as permitting D.P. physicians to take the state board exams or lowering barriers for D.P.'s, in order to ease the doctor shortage. This is as it should be.

But why isn't the same consideration given to our own so-called "B" men—the graduates of unapproved American medical schools, who are allowed to practice in only two or three states? Most of these doctors have been compelled to remain as residents in hospitals year after year, while alien physicians are now permitted to practice in almost every state. Shouldn't charity begin at home?

Peter Illberg, M.D.
Petersburg, Va.

No More Fences?

SIRS: Your recent editorial cartoon, showing doctors fenced in by state restrictions on licensing and reciprocity, should be brought to the attention of our lawmakers. Sickness knows no boundaries, and a physician will kill no more patients in another state than he does in his own.

Why not have a central licensing board in Washington, where a doctor who has passed a regular state examination can register his license and, by paying a nominal fee, obtain the right to practice in any state?

M.D., Massachusetts

Many physicians would object to increased Federal *control over the profession. The editors believe, however, that uniform* state *licensing laws could solve the problem without violating states' rights.*

Indigent Care

SIRS: There is a particularly challenging statement in Roger Menges' article "Private Care for Public Patients," which describes the Lake County, Ind., plan for medical care of the indigent. Says Mr. Menges: "Perhaps the major weakness of the plan is its lack of provision for people who are self-supporting but who can't afford adequate care."

Here, I believe, is the greatest motivation toward socialized medicine with all its accompanying hazards. When we place a premium on indigence, are we not encouraging some non-indigents to envy those who are recipients of public funds?

An insidious psychological pro-

Includes the most potent and economical liquid oral penicillin product available—plus

- *A complete range of dosage forms and potencies to suit your varying needs—*
- *Identified by one easily remembered name—Dramcillin—*
- *Provides buffered penicillin G potassium, the oral efficacy of which is long established.*
- *Presents Sulfacetimide as a component of all penicillin-triple sulfonamide combinations.*

New DRAMCILLIN-500 . . .

(500,000 units of penicillin per teaspoonful)*

Highest potency liquid oral penicillin available. Most economical liquid oral penicillin available. Fully effective on convenient 8 to 12 hour dosage schedule.

New DRAMCILLIN-250 with Triple Sulfonamides . . . *and* *New* DRAMCILLIN-250 TABLETS with Triple Sulfonamides

(250,000 units of penicillin and 0.5 Gm. mixed sulfonamides† per teaspoonful or tablet)*

Effective two-fold attack against wider range of microorganisms
Minimizes possibility of development of drug-resistant organisms

DRAMCILLIN-250 (250,000 units* per teaspoonful).

DRAMCILLIN — (100,000 units* per teaspoonful).

DRAMCILLIN with Triple Sulfonamides — (100,000 units of penicillin* and 0.5 Gm. of triple sulfonamides† per teaspoonful).

Also: **DROPCILLIN**—(50,000 units* per dropperful).

Buffered crystalline penicillin G potassium
0.167 Gm. each of sulfadiazine, sulfamerazine and *sulfacetimide* (the sulfa of choice as the third component)

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not a blemish on her...

Desiccate those unsightly, possibly dangerous skin growths with the ever-ready, quick and simple-to-use Hyfrecator. 90,000 instruments in daily use.

Please send me your new four-color brochure showing step-by-step technics for the removal of superficial skin growths.

Doctor_____

Address_____

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cess is set in motion when a hard-working family is unable to provide needed medical care, while the welfare family next door enjoys unlimited and costly treatment. There is something very wrong with an economy that provides more for the man who does not try to support his family than for the man who does.

M. Huntoon Williamson, Director
Social Service Department
Pierce County Hospital
Tacoma, Wash.

To Split or Not

SIRS: Your fee-splitting articles have covered the ground well, and with logic. But there's one phase of the problem that stumps me:

The author insists that each physician should bill the patient for services rendered, preferably in a separate envelope. How does this apply to the large medical groups and clinics?

In most of these, a patient may be examined by as many as six or more physicians; he may then be operated on by a surgeon designated by the chief of staff; and his aftercare may be in the hands of still other doctors. Does medical ethics apply to retail, and not to wholesale, medical practice?

W. B. Atkinson, M.D.
Campbellsville, Ky.

According to the Cole Committee of the American College of Surgeons, combined bills may be sent by bona fide groups whose members are on a salary or partnership arrangement, or by hospitals whose staffs have authorized the sending of single bills that itemize each practitioner's fee for services.

SIRS: The more I read about the evils of fee splitting, the less sense it all makes. Invariably, the point seems to be that the lowly G.P. sells his patient to the highest bidder and steals the fee.

But what are the facts?

In the days before hospitals were readily accessible, the surgeon used to come to the patient's home by horse and buggy, sometimes bringing along a nurse or anesthetist. He and the family doctor would transform the dining room into an operating room, and then the surgeon would perform the operation. The fee for an appendectomy, say, generally ranged from $100 to $200. But that was the total cost to the patient. No extra bills for anesthesia, operating room, and nursing.

The surgeon then got half the fee, the G.P. the rest. And, the Lord knows, each of them *earned* all he received.

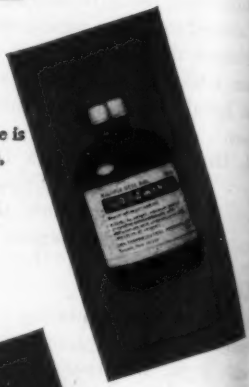
Nowadays, the surgeon spends as little as a quarter of an hour on the operation; for this he charges the same high fee as in the horse-and-buggy days. But *now* he wants to keep it all.

If the American College of Surgeons would get some of the splitting of fees off its conscience, let it recommend that surgeons cut their fees enough so that the patient can

selected for emergencies *

A recent nationwide survey[1] of the drugs carried in the doctor's bag reveals the vital significance of Coramine. As pointed out by Krantz:

"Coramine has proved its value over the years and certainly may be considered the drug of selection for acute central nervous system depression. It has largely replaced the less dependable caffeine sodium benzoate.... It should be mentioned that Coramine is gradually replacing picrotoxin in barbiturate intoxication, which lends further usefulness to this agent."[2]



Respiratory and circulatory emergencies, barbiturate poisoning, acute alcoholism, asphyxia neonatorum

Coramine®

dependable respiratory and circulatory stimulant

Ciba

Summit, N. J.

a/ssssm

1. Mattie, E.: Current Med. Dig. 19:23, 1952. 2. Krantz, J. C., Jr.: Current Med. Dig. 19:27, 1952.

CORAMINE (brand of nikethamide) issued as a 25 per cent aqueous solution in ampuls 1.5 and 5 cc., multiple-dose vials 20 cc., and oral solution 30, 90, and 473 cc.

afford to take care of the nurse, the anesthetist, *and* the G.P. That, I submit, is the only honest answer to fee splitting.

H. O. Walker, M.D.
Huntsville, Ala.

SIRS: From your articles on fee splitting it would appear that the general surgeon would like to pick up all the "marbles" and let the general practitioner work for nothing. If the surgeon calls the G.P. in as an assistant—which is the usual courtesy—and the G.P. takes an assistant's fee, this supposedly constitutes fee splitting. My sense of honesty doesn't stretch that far, since I don't believe the G.P. is on a charity basis.

My idea has always been that fee splitting occurs only in one of two situations: (1) when a G.P. sends a case to a surgeon and the surgeon pays him a kickback without the knowledge of the patient; or (2) when the surgeon pays the referring doctor more than the customary assistant's fee, again without the knowledge of the patient.

As long as the patient is aware of the individual fees included in his surgical bill, that, in my opinion, is *not* fee splitting. When a price is quoted for the surgery, it should be itemized as to surgeon's fee, assistant's fee, and anesthetist's fee. In our group office, the patient sometimes pays the amount in full and asks us to forward the assistant's and the anesthetist's fees, and we do so as a convenience to him. If this is ethically wrong, I'd like to know why.

If the present trend continues, if the G.P. is forced into office practice only and into referring all his hospital cases to specialists, then I believe the hospitals should be divided into general practice hospitals and hospitals for specialists. In that way, the G.P.'s will at least have beds for their hospital cases.

The present trend places general practitioners at an even lower level than osteopaths, who can perform their surgery in their own hospitals with considerably more privileges.

M.D., California

SIRS: The arguments against fee splitting have degenerated to a legalistic and emotional level. It's high time to examine the problem objectively.

The practice of fee splitting is with us because of three factors:

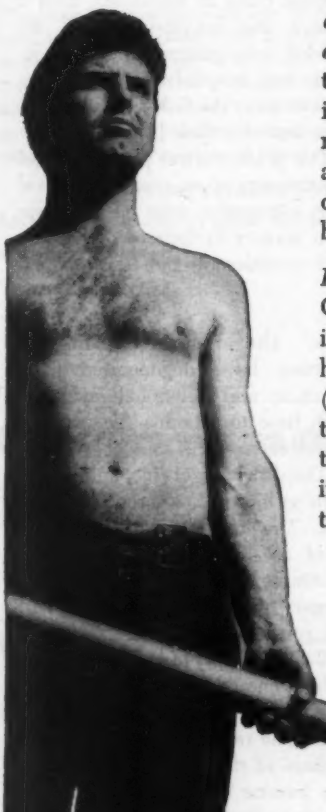
1. The fees for surgical treatment are high enough to make it profitable for the surgeon to practice surgery while sharing the fee with the referring physician.

2. The supply of trained surgeons is high enough to create a competitive market.

3. The referring physician needs a share of the surgical fee to bring his income up to his specializing brother's level.

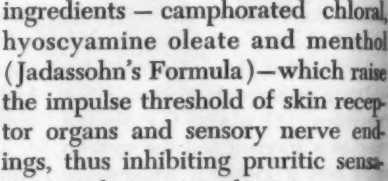
As long as the above statements remain true, so long will fees be split in practice, regardless of all the pious resolutions and condemnations. [MORE→

even the hardiest skin...



is not immune to pruritus, *nor immune to the irritating action of such antipruritic agents as phenol (in calamine & phenol),*[1] *and not immune* to the sensitization reported following antihistaminics. Calmitol Ointment controls pruritus—promptly and lastingly and is safe for the tenderest of skins, for mucous membranes and even excoriated lesions.

In contradistinction to calamine,[1] Calmitol offers active antipruritic ingredients — camphorated chloral, hyoscyamine oleate and menthol (Jadassohn's Formula)—which raise the impulse threshold of skin receptor organs and sensory nerve endings, thus inhibiting pruritic sensations at their point of origin.



1. Underwood & Gaul: J. A. M. A., 130:249, 1946.
2. Goodman, Herman: J. A. M. A., 129:707, 1945.

Thos. Leeming & Co. Inc.

155 East 44th Street, New York 17, N.Y.

Laws to suppress fee splitting simply drive it underground, and in the long run it's the patient who suffers. The opponents of fee splitting seldom take into consideration the welfare of the patient. But, in the final analysis, the welfare of the patient must remain the deciding principle.

M.D., Illinois

Legal Risks

SIRS: "Your Legal Risks in Anesthesia," by Stanley Neustadt, was a welcome article, but there is one thing about it that puzzles me. It seems to imply that the surgeon alone is legally responsible for mishaps. Should the nurse or the anesthetist, then, follow the surgeon's orders blindly, in the belief that they are in no way liable for the outcome?

Some newer anesthetic procedures are too complex to be appreciated without special training. Suppose neither the nurse-anesthetist nor the surgeon has had such training, yet the surgeon insists on using one of these new procedures. Should the nurse obey, even though she knows that neither he nor she can deal with possible complications?

Or suppose that the surgeon who has had no special experience in anesthesiology insists that an anesthesiologist perform a procedure that the latter has ample reason to fear? Is the anesthesiologist to be blamed in a damage suit for following the surgeon's orders?

It is my impression that the general rule of law holds a person liable for wrongdoing, even if he has been *ordered* to perform the action.

W. Allen Conroy, M.D.
Chicago, Ill.

Says John H. Hunt, executive secretary of the American Society of Anesthesiologists: "I personally believe that Dr. Conroy's impression of the law is well founded. It is a basic legal axiom that no person can escape the consequences of his own negligence. Thus the anesthetist will always be responsible for any damage resulting from his or her negligence.

"Perhaps, however, a practical distinction may be drawn between such a person as the nurse-anesthetist and the trained anesthesiologist. The anesthesiologist would obviously be less likely to escape liability for negligence (even under the surgeon's orders) than would the nurse."

Malpractice Insurance

SIRS: A recent news item in your widely read publication told about a malpractice-suit victim whose $5,000 malpractice policy afforded "only enough insurance to pay for legal costs and none to meet a judgment against him."

This story, reportedly based on a bulletin issued by the Bronx County (N.Y.) Medical Society, left the reader with but one conclusion: namely, that the amount of malpractice insurance a physician carries is depleted by the cost of

defense and that situations ... arise in which the cost of de... would entirely consume the ... ance carried.

Such a conclusion is erron... Malpractice insurance policies ... versally provide for payment of ... cost of defense, regardless of ... amount, and also for payment ... damages up to the limit stipula... in the policy.

As an illustration, I might c... case resulting from loss of sigh... one eye, wherein the insura... company paid $9,719.92 for defe... efforts in four trials, after whic... then paid damages of $5,000 ... addition. In this one case there ... a total monetary protection to ... doctor of $14,719.92 under a $5... policy.

It should reassure your reader... know also that such insurance ... icies provide for the same unli... defense under a $5,000 policy ... they do under a $100,000 policy, ... would under a $1 million policy ... such were issued. Enlarging the p... icy does not enlarge the defense ... can't, because the defense is ... limited in all contracts written.

T. E. Haberl...
The Medical Protective Compa...
Fort Wayne, In...

Benefits for Aides

SIRS: A recent Speaking Fra... letter, signed "R.N., Arizona," ... points out that office nursing is ... tremely hard work and one of ... most underpaid of all professi... The writer does not, however, m... tion another disadvantage of ...

In every count... *superior* vitamin supplements for infants

acceptability

The superior flavor of all three "Vi-Sols" assures patient acceptance. Mothers appreciate their convenience, too.

dispersibility

With their clear, non-sticky texture, the "Vi-Sols" disperse instantly in fruit juice or water; mix readily with formula.

hypoallergenicity

Since all their vitamins are in synthetic form, the "Vi-Sols" are well tolerated even by allergic patients.

stability

Stable at room temperature, the "Vi-Sols" require no refrigeration. They may safely be autoclaved with the formula.

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TRI-VI-SOL
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Available in 15 and 50 cc. bottles, with calibrated droppers

	Vitamin A	Vitamin D	Ascorbic Acid	Thiamine	Riboflavin	Niacinamide
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Vi-Sol	5000 Units	1000 Units	50 mg.			
Vi-Sol			50 mg.			

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at that age
when the taste
of things can be
so important...
The natural orange flavor of
Mulcin
puts a smile in the vitamin spoon
Even at the ages when vitamin supplementation is often a problem, children like Mulcin. The refreshing orange flavor, smooth, non-sticky texture and appealing color of this vitamin emulsion win ready acceptance. And there's no unpleasant aroma or after-taste. Mulcin does not need refrigeration; even at room temperature, its potency is assured.
Available in 4 oz.
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Pharmaceutical Elegance
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a doctor's aide. As the sole employe of a physician, the aide does not enjoy such group benefits as unemployment compensation and hospitalization insurance.

Couldn't some plan be worked out through the medical societies whereby aides could register *as a group* to receive these benefits?

Irene Jensen
Monrovia, Calif.

Too Old

Sirs: After reading Dr. Howard A. Rusk's statement in the April Newsvane that industry needs more doctors, I sent applications to two plants doing war work. One ignored my letter; the other gave me the brush-off because, I believe, they considered me too old.

By refusing to hire any but very young doctors, industry is itself creating the shortage of industrial physicians.

Philip P. Hayman, M.D.
New York, N.Y.

Insurance Payments

Sirs: In one of your news columns, not long ago, Dr. Edward B. Tyson raised the question of what to do about patients who collect from an insurance company for medical treatment and then keep the money instead of paying the doctor. I lost plenty before I hit on a solution to this problem. But I think I've now found the answer:

When a patient who has insurance comes in for treatment, I ask him to sign a typewritten form say-

ing: "I hereby authorize the Bl
Insurance Company to pay any su
of money due me for medical ser
ice, under the terms of my poli
directly to Dr. Daniel Beltz." If
refuses to sign, which rarely ha
pens, I ask the insurance compa
to put my name as well as the p
tient's on the check, so that bo
signatures will be necessary fo
cashing it. Usually, the compan
complies.

Daniel Beltz, M.
Los Angeles, C

SIRS: We have solved the probl
by requesting the patient to as
the benefits under his policy to
doctor. This has become a rou
procedure in our office. We expl
to the patient (quite truthfully) th
insurance companies often mak
payment to the doctor or hospit
more promptly than to the insured
We also remind him that direct pay
ment will save him the trouble o
writing a check or bringing in the
money.

M.D., District of Columbi

SIRS: Forms authorizing payment
directly to the physician may be ob
tained from many insurance com
panies.

Richard D. Kepner, M.D.
Honolulu, Hawai

Doctors Jacobi

SIRS: I should like to point out three
errors in Ross C. McCluskey's re
view of my book, "The Doctors
Jacobi." He writes: "Working wit
Elizabeth Blackwell in the new

IMPRESSIVE NEW EVIDENCE CONFIRMS

striking benefits *in* resistant acne

KUTAPRESSIN*

CUTANEOUS VASOCONSTRICTING PRINCIPLE FROM LIVER

In a series of 22 cases of acne vulgaris resistant to all conventional methods of treatment (including massive vitamin A therapy), Nierman[1] has obtained remarkable results with **KUTAPRESSIN***... confirming previous observations of Marshall[2,3] and others,[4,5] who used early forms of this preparation.

ALSO VALUABLE IN PRURITUS ANI AND KELOIDS—Marshall[6] has reported relief of distressing symptoms in 16 cases of pruritus ani treated with **KUTAPRESSIN**, and has found the drug effective in reducing the size and disfiguring appearance of keloids.[2,3]

CLINICAL RESULTS WITH KUTAPRESSIN[1]

- Disappearance or marked amelioration of pustules and other lesions
- Regression of scars and pits, usually amenable only to surgery
- Early improvement, securing enthusiastic patient-cooperation
- New social and economic outlook for patient

SUPPLIED: In 10-cc. multiple-dose vials.

REFERENCES: 1. Nierman, N. M.: J. Indiana M. A. (in press). 2. Marshall, W., and Schedeberg, W.: Wisconsin M. J. 49:369, 1950. 3. Marshall, W.: M. Times 79:222, 1951. 4. Stillians, A. W.: Mississippi Valley M. J. 64:135, 1942. 5. Lichtenstein, M. R., and Stillians, A. W.: Arch. Dermat. & Syph. 45:939, 1942. 6. Marshall, W.: Mississippi Doctor (Aug.) 1951.

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K-U

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established Women's Medical College of New York, [Dr. Mary Putnam Jacobi] was one of the first women medical teachers. With her husband, she helped to establish New York's Mount Sinai Hospital."

It was not Dr. Elizabeth Blackwell but her sister, Dr. Emily Blackwell, with whom Mary Putnam worked at the Women's Medical College.

Nor did I imply that Mary Putnam was one of the first women medical teachers; she had been graduated in 1864 from the (then) Female Medical College of Pennsylvania, established in 1850, and I described a number of women doctors who taught there and elsewhere long before Mary Putnam became a medical teacher.

Obviously, too, she did not help her husband found New York's Mount Sinai Hospital, for she was born in 1842 and the hospital was founded in 1852. It was the pediatric clinic that they established after their marriage in 1873.

Mr. McCluskey, of course, is fully entitled to his opinion that the author "has let herself become distracted by unimportant, irrelevant material. The consequence is a great deal of tedious description of political and economic issues of the day." The fact is, however, that the political and economic issues of the day were vitally important to the Doctors Jacobi, as everyone familiar with their careers knows.

Rhoda Truax
Cambridge, Mass.

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- ☑ Backed by extensive clinical studies on animal and human subjects...
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- ☑ Manifests a gratifyingly low incidence of sensitization...
- ☑ Of proved value in the prophylaxis and therapy of *miliaria, excoriated buttocks, diaper rash, impetigo,* and *cradle cap*...
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Peak Performance with Portability

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VC-5000 PORTABLE
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Despite its ready portability, this rugged, ACMI-engineered short wave diathermy unit gives peak performance for optimal deep heat therapy or precise electrosurgery. High power output, conveniently and safely controlled, permits unusual flexibility.

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Model VC-5000 is handsomely encased in a sturdy, all-steel cabinet with lasting scratch- and crack-proof enamel finish.

Standard accessories: 1 inlet cable; 2 heavy rubber condenser pads, 7" x 10"; 1 inductance cable; and 4 heavy, perforated felt spacers, 8"x11".

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Acting concurrently, the components of Syntil combine central stimulation with mild, relatively prolonged sedation—thus producing simultaneously

- ..... elevation of mood; sense of well-being and efficiency—through the action of Syndrox® Hydrochloride
- ..... relaxation of nervousness, tenseness; relief of anxiety—through the "intermediate sedative" action of Butisol® Sodium

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Each scored yellow tablet contains:
Syndrox® Hydrochloride... 2.5 mg.
Butisol® Sodium..... 15 mg. (¼ gr.)

SUPPLIED: Tablets Syntil are supplied in bottles of 100 and 1000. Samples on request.

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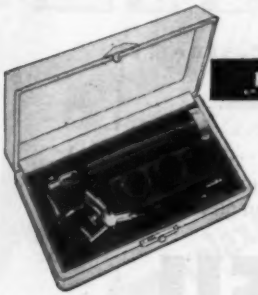
ARC-VUE OTOSCOPE

This fine instrument provides the brightly lighted field so important to fast, easy diagnosis and so vital in surgery. In addition, the swinging arc of the speculum mount is so devised as to give a 36% larger operative field than previous instruments. Head includes tongue depressor holder and 4 specula, including nasal. In attractive, durable case.



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Designed for maximum speed and ease of use. Includes Arc-Vue Otoscope with 4 specula, and May Ophthalmoscope, battery handle and extra lamp, in durable carrying case.

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Hand Diagnostic INSTRUMENTS

massage . . .

"an indispensable agency in control of significant features of many disease processes."[1]

As "the renaissance in physical therapy promises that this oldest of healing arts will again come into its own,"[2] physicians, nurses and physical therapists have become increasingly aware that the lubricant chosen may be a factor in the success of massage therapy.

[1] and [2] — "Massage — Physiologic Basis," Arch. Phys. Medicine, March 1945. Presented as part of Instruction Course, Twenty-third Annual Session, Amer. Congress of Phys. Medicine, Cleveland, 1944

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for massage and bed sore prevention measures—NOW WITH ANTISEPTIC VALUE

The soothing, emollient character of Dermassage, the protective value added by germicidal hexachlorophene and the cooling effect of menthol—these combine to make Dermassage a logical aid to patient skin care. The lanolin and olive oil content lubricates skin surfaces, reduces likelihood of cracks and irritation. Hexachlorophene minimizes the risk of initial infection, gives added protection where skin breaks occur despite precautions.

CLIP THIS CORNER to your LETTERHEAD for a Liberal Trial Sample of EDISONITE SURGICAL CLEANSER

Instruments come spotlessly clean and film-free after a 10-to-20 minute immersion in Edisonite's probing "chemical fingers" solution. Harmless to hands, as to metal, glass and rubber. EDISON CHEMICAL COMPANY, 30 W. Washington St., Chicago 2.

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Please send me, WITHOUT OBLIGATION, your Professional Sample of *DERMASSAGE*.

Dr. _____

Address _____

"Time and attention," wrote William Heberden in 1768 of the syndrome he had named *angina pectoris*, "will undoubtedly discover more helps against this teizing and dangerous ailiment."[1]

Today, a variety of "helps" are used in the treatment of this "teizing and dangerous ailiment." One of the more effective: 'Eskel', reported by Osher and Katz to be beneficial in 80% of cases.[2]

in angina pectoris 'Eskel'

the longest-acting coronary vasodilator

1. Read at the Royal College of Physicians, July 21, 1768.
2. New England J. Med. *244*:315 (March 1) 1951.

Smith, Kline & French Laboratories, Philadelphia

'Eskel' T.M. Reg. U.S. Pat. Off.

Sidelights

One-Basket Investors

For years, stockholders have been warned about the need to diversify holdings. It's dangerous, they've been told, for a person to put all his eggs in one basket. Yet look at a recent survey of stock ownership, conducted by the Brookings Institution.

You find that 46 per cent of all shareholders own only one stock issue; that 72 per cent own three issues or less; that a mere 8 per cent own ten or more issues.

The doctor who follows this stockholding pattern may well be inviting trouble. For even quality stocks react in widely different ways.

Consider the performance from August 27, 1945, to May 26, 1949, of the thirty top-drawer stocks that make up the Dow-Jones industrial average. The average itself showed neither gain nor loss over the four-year period. Not so the individual blue-chip stocks. Their price movements varied from a net gain of 51.1 per cent to a net loss of 39.2 per cent (twelve of the stocks went up, eighteen went down).

Thus, even during a stable period, the one-stock investor is assuming a pretty big risk. He may come out ahead, or he may wind up with a loss. But the man who owns a number of stocks spreads his risk, minimizing the speculative element. The more diversified his holdings, the more likely they are to reflect the position of the market as a whole.

Even the investor who buys mutual fund shares as a means of spreading his risk is well advised to diversify: Let him buy not into *one* fund but into *several.*

Campaign Warning

Are the thousands of doctors who do per diem work for the Government restricted from taking any part in this year's national political campaigns? As pointed out in May MEDICAL ECONOMICS ("Are You Campaigning Legally?"), they probably are.

If you have the remotest doubt about your own status, better check into the matter carefully. For the Government might just try to make an example of some prominent doctor engaged in illegal electioneering.

More than one medical society has warned members about this. So a number of doctors, like former A.M.A. President Elmer L. Henderson, have given up their per diem work, in order to free themselves for political activity. [MORE→

The ground rules for part-time Government doctors aren't crystal clear. But the following questions and answers should shed some light on your position. They're based on information supplied by the legal firm of Kirkland, Fleming, Green, Martin & Ellis, which is advising the A.M.A. on the same subject.

What's the authority for campaigning restrictions on part-time Government doctors? Circular 3301 of the Department of Justice. It puts temporary, substitute, and per diem employes of the executive branch of the Federal Government under Hatch Act provisions that prohibit political activity.

Do these restrictions apply to doctors who work for Federally financed state and local agencies? Yes, if the doctor's main public job is connected with any activity financed even in part by the Federal Government.

Are there any exceptions? You're free to campaign (1) if you work for an educational or research institution or system supported in whole or in part (a) by state or local government, or (b) by a recognized religious, philanthropic, or cultural organization; (2) if you are retained to perform special services on a fee basis and have taken no oath of office.

When do these restrictions apply? Probably during the entire period of your Government contract, if you have one. Otherwise, only during the period of "active employment" (assuming that your Government work takes but part of your time

Only on your Rx . . .

When prescribing Ergoapiol (Smith) with Savin for your gynecologic patients, you have the assurance that it can be obtained only on a written prescription, since this is the only manner in which this ethical preparation can be legally dispensed by the pharmacist. The dispensing of this **uterine tonic**, time-tested ERGOAPIOL (Smith) WITH SAVIN —only on your prescription—serves the best interests of physician and patient.

INDICATIONS: Amenorrhea, Dysmenorrhea, Menorrhagia, Metrorrhagia, and to aid involution of the postpartum uterus.

GENERAL DOSAGE: One to two capsules, three to four times daily—as indications warrant.

In ethical packages of 20 capsules each, bearing no directions.

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Literature Available to Physicians Only.

Ethical protective mark, M.H.S., visible only when capsule is cut in half at seam.

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and is a minor source of income). In other words, you're legally restricted from electioneering only on those days that you work for the Government.

Holders of Government contracts may be bound by section 611 of the Criminal Code as well as the Hatch Act. These contracts are almost always authorized by individual statutes, which vary widely in content. So it's a good idea to study the particular statute that applies to your appointment.

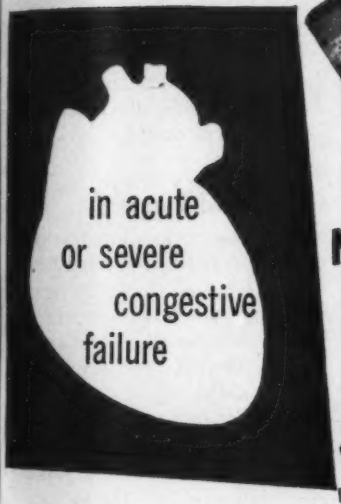
If you're not sure where you stand, check with your attorney. You might also ask the agency you work with to get an opinion from the Attorney General.

OB Champ

Who is the champion baby-deliverer of the United States?

We got to wondering about this while sifting through a recent batch of news clippings. One, for example, told the story of Dr. John A. Maronde, a 78-year-old G.P. of Monterey Park, Calif. During thirty-five years in practice there, according to an official count, he has delivered 5,104 babies. This seems to put him high on the list of those who do their obstetrics without much help.

Another news clipping told of a different kind of doctor—an OB chief in a big-city hospital, who presumably had lots of help. Even so, the record of Dr. William Sinclair Bowen (who died not long ago in Washington, D.C.) seems outstanding. During sixty years of practice,



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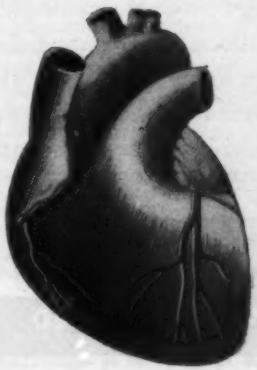
The importance of MERCUHYDRIN Sodium in relieving the "drowning" heart has made it a fulcrum of the therapeutic regime in acute or severe congestive failure. In pulmonary edema or paroxysmal nocturnal dyspnea, the prompt, effective action of MERCUHYDRIN may be a life-saving measure, as demonstrated by extensive clinical experience.

Unexcelled for draining edematous tissues, well tolerated locally and systemically, MERCUHYDRIN is an agent of choice for initiating diuretic therapy.

MERCUHYDRIN Sodium (brand of meralluride sodium) is available in 1-cc. and 2-cc. ampuls and 10-cc. vials.



Leadership in diuretic research
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he reportedly delivered more th 18,000 babies.

Do you know of a doctor in eith category whose record ranks wi these? Let us hear about him, an we'll duly consider him for our gol plated forceps award.

Cloak and Dagger

Most of the manuscripts that co to our editorial offices volunteer a vice—good, bad, or indifferent—a doctors. If the advice is good, w print it; occasionally, when it's very bad, we also print it—as an example of what *not* to do.

Take, for instance, one little gem that turned up in a manuscript tell ing how to act when a patient's check bounces. Says the author:

"A still more sure-fire way to get that check made good is to tele phone the patient, provided you're certain he can't recognize your voice or trace the call, and say: 'This is the District Attorney's office. Dr. Brown has turned over to us a worthless check you sent him. Un less it's made good within forty-eight hours, we'll lock you up.'

"Then hang up fast and await re sults, which are almost certain to be excellent. If you should be caught at this, you might be charged with impersonating a county officer; how ever, you *didn't* say the District At torney *himself* was calling—just his office . . ."

If any doctor is rash enough to experiment with this idea, we'll wel come an account of the results. Just phone us from the police station.

SODIUM ETHALYL

QUICK AND LONG LASTING HYPNOTIC

Ethalyl combines quick acting pentobarbituric acid with long acting phenobarbital. The balanced proportions of these two overlapping hypnotics act synergistically to put and keep your patient asleep.

Sodium Ethalyl is available as powder, and in blue and white combination capsules of 2 grains. Write on your letterhead for professional sample and literature.

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How this Man Helps Protect Your Recommendation of Carnation

HE'S A CARNATION FIELD MAN...a skilled specialist. As an expert guardian of Carnation quality, he makes periodic inspections of dairy farms that supply milk to Carnation plants. He checks herds, equipment, sanitary conditions... rejects milk that fails to meet Carnation's high standards. He and 150 others like him help protect your recommendation of Carnation.

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1. **Cattle from champion Carnation bloodlines are distributed to farmers all over the country to improve the milk supplied to Carnation plants.**
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but maintain protein digestion

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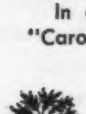

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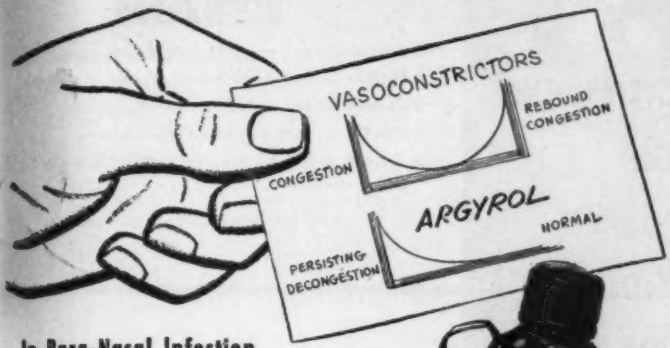

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3

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Removes intestinal toxins

RESION

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Available: Bottles of 4 and 12 fluidounces.

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Resinat . . . . . 0.5 Gm.
Homatropine ...ethylbromide . . . . . 1 mg.

1. Quick relief of ulcer pain
2. Speeds healing of peptic ulcer
3. Attracts and binds both pepsin and hydrochloric acid
4. Blocks spasm: relaxes the gastrointestinal tract
5. Coats the crater with a protective film
6. Does not cause acid rebound, alkalosis, constipation or diarrhea
7. Does not remove chlorides, phosphates, minerals or vitamins
8. Pharmacologically inert

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Removes sodium—controls edema

NATRINIL

- To reduce blood pressure in hypertension
- To relieve edema in hypertension, congestive heart failure and cirrhosis
- Controls sodium absorption with minimal dietary restriction
- Invites patient cooperation by allowing a more palatable diet
- Lessens or eliminates the need for diuretics

Available: Powder, 10 ounce bottles and boxes of 10 individual 10 gram packets.

XUM

In G.I. infections—diarrhea—nausea of pregnancy

In peptic ulcer

In hypertension, congestive heart failure and cirrhosis

in athlete's foot... 5-minute

Bactine

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routine...

for hours of relief from itching, discomfort

for hours of fungicidal, antibacterial action

Here is a simple and effective daily routine for your patients with Athlete's Foot. *Bactine* encourages cooperation because it does not sting or burn, does not stain and has a clean, fresh odor.

instruction sheet

1. Cleanse feet with *Bactine* morning and night. (Penetrating detergent action removes material favorable to fungi and bacteria. *Bactine* also helps curb foot odors.)
2. Place *Bactine*-soaked pledgets of cotton between affected toes for 2 minutes. (*Bactine* fights both fungi and secondary infection.)
3. Allow *Bactine* to dry on feet. (Action persists for hours.)
4. Each morning put on clean, dry socks previously rinsed in *Bactine* solution, one tablespoonful to quart of water, for 3 minutes. (*Bactine* helps prevent reinfection.)

Bactine: 1-gallon, 1-pint, 6-ounce and 1¾-ounce bottles. From your regular supplier, or we will assist you in ordering.

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B-15

Unusually Precise Evaluation of Ir

Recent Report Shows Value of New Biochemical Determinations*

"Six weeks of oral iron (Mol-Iron) therapy will in the anemic mother produce the equivalent of 4 transfusions at a fraction (1/40) of the cost"*

In an unusually thorough clinical study recently reported, Lund* was able to diagnose the presence of true iron deficiency anemia of pregnancy and to evaluate *with a high degree of accuracy* its response to therapy.

NEW DETERMINATIONS SHOW TRUE BLOOD PICTURE

Accuracy in diagnosis and evaluation of response to treatment was made possible by combining new biochemical diagnostic determinations—*blood volume, erythrocyte protoporphyrin, total hemoglobin mass*—with hematologic studies routinely used in clinical practice. These newer techniques permit a more accurate appraisal of the anemic state and its response to therapy since they take into account the definite but widely varied increases in plasma volume that occur during pregnancy. Such increases in blood volume, of course, considerably limit the usefulness of routine blood counts during pregnancy.

THERAPEUTIC RESPONSE TO MOL-IRON

". . . the oral administration of a molybdenum ferrous sulfate compound (Mol-Iron) effectively treated 95 per cent of a group of . . . patients with iron deficiency anemia of pregnancy."

Six weeks' treatment with Mol-Iron—providing 240 mg. elemental iron daily—produced *increases in total hemoglobin mass of 80 to 87 per cent.*

"In the severely anemic patient molybdenized ferrous sulfate (Mol-Iron) will assist in the regeneration of 45 Gm. of hemoglobin per week *or the equivalent of a 350 c.c. blood transfusion.*"

The author observed an averag

*Lund, C. J.: Studies on the Iron Deficiency Anemia of Pregnancy, Am. J. Obstet. & Gynec. 62:947 (Nov.) 1951.
(Reprint available upon request)

Iron-Deficiency Pregnancy Anemia

hemoglobin gain of 2.9 Gm. per cent in 4 weeks of Mol-Iron therapy during late pregnancy; this is almost identical with the frequently reported figure of 2.8 Gm. per cent in 3.7 weeks following *intravenous* iron.

RESPONSE TO MOL-IRON THERAPY

		BEFORE TREATMENT	WEEKS OF TREATMENT					
			2		4		6	
	TIME	MEAN	MEAN	% INCREASE	MEAN	% INCREASE	MEAN	% INCREASE
Hgb. Gm. %	Early*	7.4	8.9	13	9.6	26	9.7	28
	Late†	7.1	9.0	20	10.0	36	10.6	47
Total hgb. Gm.	Early	327	416	27	512	56	612	87
	Late	335	407	20	507	54	595	80

*Treatment initiated during the period of rising plasma volume (before 32 to 34 weeks gestation).
†Treatment initiated thereafter.

WELL TOLERATED

Of a total of 75 patients receiving Mol-Iron therapy, Lund observed only one (1.3 per cent) who was unable to continue the medication because of gastrointestinal disturbances.

SUGGESTED THERAPEUTIC PLANS

"The results of this study suggest the following therapeutic plans. If the anemia is discovered during the first or second trimester, active treatment with iron will not only restore the normal amount of hemoglobin, but will also reproduce the normal increase in total hemoglobin. Treatment may be stopped at delivery. If the anemia is discovered during the last trimester, full normal response is not usually obtained before delivery; in such cases the treatment should continue for 6 or 8 weeks postpartum."

COMMENT

Utilizing newer biochemical determinations, this study* indicates that Mol-Iron is an exceptionally effective iron preparation. Thus it gives strong emphasis to the already extensive evidence that has accumulated demonstrating the definite therapeutic superiority of Mol-Iron.[1-8]

Mol-Iron supplied as: Mol-Iron Tablets, Mol-Iron Liquid, Mol-Iron Drops, Mol-Iron with Calcium and Vitamin D (capsules), Mol-Iron with Liver and Vitamins (capsules). White Laboratories, Inc., Kenilworth, N. J.

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8. Kelly, H. T.: Pennsylvania M. J. *51*:999, 1948.

Piromen*

(DISPERSION OF DESACCHROMIN)

a new therapeutic agent for HAY FEVER

Piromen alleviates the immediate symptoms of pollenosis, and maintains effective control. Even cases which have failed to show improvement to desensitization and antihistaminics usually respond promptly to the administration of PIROMEN.

Piromen is also useful in the treatment of many other allergies and dermatoses.

Piromen is supplied in 10 cc. vials containing 4 gamma (micrograms) per cc. and in 10 cc. vials containing 10 gamma per cc.

Piromen on your Rx will bring you our new booklet detailing the use of this new therapeutic agent.

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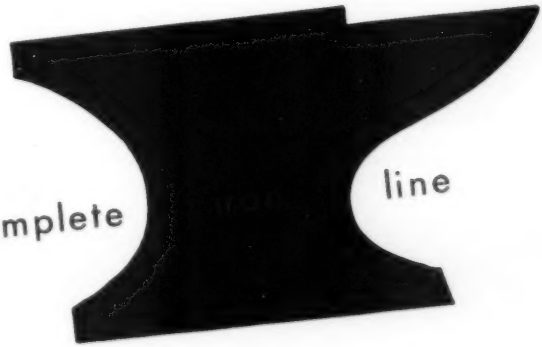


Editorial

About Eisenhower

• If Dwight D. Eisenhower becomes our next President, how will medicine be affected?

Although reams have been written about the man, a dispassionate analysis suggests that just three points have an immediate bearing:

1. *His views are generally conservative.* He has insisted, for example, that "we must support medical education by private means, because if we didn't, it would be the first step toward the socialization of medicine." He tends to think poorly of Federally-dispensed security. If *security* is all a man wants, he has said, "a penitentiary offers him his greatest opportunity."

2. *His health views have yet to be crystallized.* In medical affairs, as in other domestic matters, he has a great deal to learn. "What could be in a bill labeled compulsory health insurance?" he mused not long ago, when a reporter asked for his views in detail. "I am not so certain . . ."

3. *His health views will sharpen during the months ahead.* This is inevitable, campaign pressures being what they are. And the greatest of these pressures may come from the middle—from independent voters, who hold the balance of power. As his health views sharpen, they may tend to become less conservative.

Two catalysts in this opinion-forming process are worth special mention. First, his advisers: They include not only the orthodox medical thinkers like Stassen and Nixon, but also unorthodox ones like Warren and Lodge.

Second, his sources of information: These are pretty sure to include the controversial studies now being completed by the President's Commission on the Health Needs of the Nation.

What's the greatest *potential* catalyst in the General's thinking on health? Private medicine itself. From where he sits, this is its proving time. Its achievements, its progress, its plans for greater progress—all need to be demonstrated as never before.

In the long run, if Eisenhower is elected, the White House atmosphere can be more favorable to private medicine than it has been for twenty years.

In the meantime, what *we* think about Eisenhower may be less important than what *he* gets to know about us.

—H. SHERIDAN BAKETEL, M.D.

Do Patients Accept Your Advice?

If some of them don't, it will pay you to read these tips on the art of convincing people

● How does a doctor most often offend his patients?

By giving them the right advice in the wrong way.

Advice-giving is a ticklish business at best. Unfortunately, it is also one in which a doctor may give unintentional offense more easily than almost anyone else.

For one thing, medical advice often deals with things the patient isn't happy to hear about. And much of it touches on intimate details loaded with the seeds of acute embarrassment.

But there are ways of reducing the risk. Some doctors have developed advice-giving techniques that are nearly foolproof. And a good many patients, after rejecting what Dr. X told them, have later accepted exactly the same advice from Dr. Y, who served it up in a different manner.

No matter what counsel you have to give, or to whom you're about to give it, you'll get better results if you keep in mind a few simple rules:

1. *Lead your patient to the psychological point at which he'll be most receptive to the advice.* And remember: He won't be receptive unless he has some idea of the reasons for it.

A nurse who had worked for five doctors over a twenty-year period told me: "Only one of them didn't have seven or eight patients walk out dissatisfied every week. The patients would often ask me if *I'd* follow the advice of a doctor who wouldn't explain the sense behind it. I couldn't tell them, of course—but I wouldn't."

But don't such explanations take too much time? Not necessarily, say doctors who make a point of them. Explanations needn't be long drawn out. Most of them can be made during routine procedures, when there's usually some conversation anyway.

In hard-to-advise cases it's wise to heed the well-known axiom: The more dissatisfied a patient is with his present condition, the more

---

By David Rutherford

**The author, who writes here under a pen name, is a clinical psychologist on the staff of a state hospital in the East.*

adily he'll accept advice for correcting it.

Take the case of a young insurance salesman whose leg, injured in an automobile accident, had mended badly. No amount of argument could make him agree to the surgery recommended.

"So I stopped arguing," said the doctor. "Instead, one day, I got him talking about himself. In no time he was telling how his bad leg interfered with calls on prospects, reduced his income, and left him worn out at the end of the day."

The doctor grinned. "Before he knew it, that fellow had shown *himself* how the bad leg was hampering his career and spoiling his enjoyment of life. In ten minutes he'd sold himself the recommendation I couldn't interest him in. He had the operation. And now his leg is as good as new."

Even when the patient's present condition isn't too bad, you may want to point out how neglect of your advice might make it worse. In any case, a patient has a right to know what the total results of his treatment may be.

This warning against possible future trouble works well for a pediatrician I know. She used to find that only 10 per cent of the parents to whom she recommended a child guidance clinic actually took their children there.

But things changed when I began to show the parents that their children's problems might grow worse," she says, "—that the youngsters might grow up to be poor social personalities, poor career risks, poor citizens. Now about 75 per cent of them act on my referrals."

Many doctors who have tried "conditioning" patients for advice tell me the results have been little short of miraculous.

2. *Let your patient feel he has a hand in making the decisions that will affect him.* He isn't, after all, a horse to be hitched to a wagon and driven off in whatever direction his doctor chooses.

A gynecologist I know can't understand why he always seems to have an uncommonly uncooperative lot of patients. His colleagues wonder if it isn't because he addresses his advice to them in the tone and manner of a drill sergeant barking at an incompetent rookie.

The dictatorial approach, far from keeping the patient in line, may have the opposite effect. Feeling that his ego has been slighted, he's apt to disregard the advice as a means of reasserting his independence.

On the other hand, when a patient takes part in a decision, he feels responsible for carrying it out.

One way to give the patient a sense of being in on things is to pitch the advice from his corner. As a young gastro-enterologist put it to me: "I started getting real cooperation from my patients the day I stopped saying, '*I* want you to take this medicine, Mrs. Jones.' By changing it to, '*You'll* find this medicine helpful,' I was talking Mrs.

Guarding the Gate

nes' language and bringing her o the act."

Best of all is to have the *patient* ggest the advice. A well-known diologist has been using this thod with gratifying success. ere's his formula:

"I sketch for the patient all the cts I think he needs to know. ey're slanted, of course, so he can e plainly what anyone in his con- tion ought to do. Then I say, 'If u were the doctor, and I the pa- nt, what would you advise *me* to ?' Almost always he suggests etty much what I had in mind for im—and all I have to do is fill in e details."

In short, the more you can make e patient feel he's helping to ape the advice he's getting, the etter the result.

3. *Spare your patient embarrass- ent by taking a factual, dignified pproach to intimate subjects.* Not any people, even in these free- oken days, can discuss details of eir more intimate bodily functions ithout self-consciousness.

How to approach these matters is e of the doctor's most trouble- me problems, especially since the rson across the desk may react in y of several ways. Only one thing sure: That reaction will depend lmost entirely on the doctor's atti- de. If the M.D. squirms, gets red the face, or cracks his knuckles, e patient's discomfort is likely to atch his own.

"First time I advised a patient bout a very personal matter," one doctor recalled, "I tried a casual, off-the-cuff, somewhat earthy style. It didn't work. It created a pool-room atmosphere that made us both uncomfortable.

"Since then I've learned to discuss intimate problems warmly but with detachment. I try to approximate the attitude I'd take, say, with a troublesome ingrown toenail."

Patients and doctors generally seem to agree that the "indelicate" problem is best treated factually. Let it be brought up as a perfectly natural subject for discussion and one that calls for no apology.

4. *Try to make your disagreeable advice palatable.* Here, as in many another case, the sugar-coated pill has it all over the bitter one.

The patients of an internist I know are the envy of his colleagues. They never rebel when he gives them hard-to-take advice. They accept it willingly, and thrive on it.

"It's all because of a little trick of giving the patient a chance to feel noble and unselfish," this doctor confessed to me. "People actually feel good about making a painful sacrifice if they think it will help someone they care about—a wife, a mother, or the children. That man who just left my office has agreed to a strict diet for the sake of the Little Woman. He'd never have undertaken it just for himself."

The head of a well-known clinic adds this tip: A patient can often be persuaded to stick to an utterly repugnant regimen by adroit references to his courage, his integrity

and, in particular, his will power.

He can indeed. As a friend of mine confided recently: "The doctor said he wouldn't think of prescribing this diet for the ordinary person, but he thought *I* might have the guts to stick to it. And it isn't so bad, now that I'm used to it."

People will put up with a lot of discomfort if it enables them to think of themselves as better, stronger, finer persons. This is a good thing to keep in mind whenever you're about to dispense your most distasteful advice.

5. *Be prepared for the occasional patient who, having considered your advice in its most beguiling aspects, still won't have any part of it.* You won't meet him often; but when you do, an extra set of emergency precepts will come in handy.

An astute general practitioner with whom I've discussed this problem makes these suggestions:

¶ Let the patient express his objections fully and freely. It's quite possible he'll talk himself around to your point of view.

¶ Repeat his arguments after him. Let him know you understand why he feels as he does and that there's something to what he says. W he finds you arguing from his p of view, he may reverse himself start arguing from yours.

¶ Make it clear that your pat has a perfect right to make up own mind whether or not to t your advice. If he's protesting because he feels a need to as himself, he'll probably give in you've recognized his independe

¶ If everything else fails, le the way open for the patient come back another time. If y haven't insisted that he take yo advice, he may think it over in p vate and come to see it your wa

"I used to lose arguments w patients consistently, no ma how good my points," this doc says. "Now, when a patient agrees with me, I sit back and him argue with himself. Result: nearly always win."

A physician can't avoid givi the advice that's demanded of h daily, come Johnny with his ra Dad with his asthma, and Grand with her rheumatism. But he c tune up and lubricate his advic giving techniques—and so avoi lot of needless friction.

Thyroid Thrill

A doctor has to cultivate austerity
And dodge his female patients with celerity.
The only thrills he can afford to loiter for
You've got to mess your neck up with a goiter for.

—EMILY BARNHART

M.D.'s Battle It Out With D.O.'s

Here's what happened when osteopaths got in and the M.D.'s got out at Bay City

• Last June 9 the city commissioners of Bay City, Mich., voted five to four to let osteopaths practice on an equal footing with M.D.'s in the Bay City General Hospital. The next day, the seventy staff M.D.'s of the city-owned institution, rather than jeopardize their ethical standing and appear to condone any lowering of the hospital's standards, staged a walkout—or as they preferred to call it, a "force-out."

For a week, the so-called "hospital boycott" made newspaper headlines in many another city where physicians knew they might some day face a similar test. Then a dismayed city commission revised its decision and called off the D.O.'s.

Despite this reprieve, the issue in Bay City is by no means settled. This November, in a referendum engineered by the osteopaths, Bay City voters will decide whether to admit them again to the hospital. If as a result the osteopaths return, the M.D.'s have vowed to repeat their walkout. [MORE→

By James C. Fuller

Scene of this classic inter-professional fight is the Bay City public hospital. Medical leaders involved include Dr. L. Fernald Foster (left), chief of staff, and Dr. A. L. Ziliak (right), president of the local medical society.

Why did it happen? What took place during that hectic week in Bay City? What did the M.D.'s gain by their drastic action? Here is the story:

For many years, the municipal hospital in Bay City (pop. 53,000) has been governed by the nine-man city commission, with the city manager acting as administrator. Last spring, however, Bay City voted on a proposal to take the hospital administration out of politics and turn it over to a board of lay trustees. The plan was defeated—due in part to the opposition of osteopaths. Their apparent motive: a non-political set-up might stymie their chances to practice in the hospital.

The battle over this measure had two significant by-products: (1) During the campaign, the city attorney held that the city could not lawfully bar osteopaths from the tax-supported hospital; and (2) the osteopaths, stimulated by their success, renewed their long-standing campaign for admission. Prompted by these pressures, the city commission made its pro-osteopath decision.

M.D.'s Give Warning

Two months before the commission acted, however, Bay City M.D.'s, knowing that the issue was headed for a showdown, sent the commissioners an ultimatum:

To admit osteopaths to the hospital, the M.D.'s predicted, would lead to immediate loss of its accredited status with the national medical and hospital organizations. "When this occurs," they said, "and standards are thus lowered, the doctors of medicine, much against their will and with regret, will be forced to dissociate themselves from the General Hospital staff."

Thus the promptness of the M.D.'s in quitting the hospital should not have surprised the city's governing board. Yet obviously it did.

The commission's Monday-night order to admit the osteopaths took effect immediately. At noon, Tuesday, fifty members of the Bay County Medical Society met in emergency session. Unanimously they voted to send no new patients to General Hospital and to schedule no more cases for surgery. But they would, they promised, care as usual for their patients still confined there. (Since it was the summer slack period, the daily census of patients in the 154-bed hospital had been averaging only about 115.)

During Tuesday, the M.D.'s at the hospital performed eleven previously scheduled operations. But already they had begun to transfer patients to Bay City's 300-bed Mercy Hospital and to send home those whom they could safely discharge. By Wednesday, there were only eighty-eight left.

As yet, none of the city's eight osteopaths had showed up at the hospital. But Wednesday morning their spokesman, Dr. Hobert C. Moore (head of the fifteen-bed Bay Osteopathic Hospital and a former vice [MORE ON PAGE 189]

Since you can spend money and still not get results in subduing the sounds that bounce off or go through the walls of your office, you need the advice of experts. Here it is.

How–and How Not–to Soundproof

A doctor we know has an office whose consultation and treatment rooms adjoin the reception room. Through the walls between pass the sounds of equipment being used, of toilets being flushed, of children howling, and—worst—of patients engaged in intimate conversation with the physician.

This M.D. decided some time ago that he knew how to solve the problem. He'd noticed the quieting effect of sound-absorbent tiles in restaurants and other public places. So he had a contractor install similar acoustic tiles on the ceiling and walls of his treatment and consultation rooms.

How did it work out? It didn't.

True, the sounds inside these rooms seemed muffled. But they were still being transmitted through the walls in a manner almost as audible and embarrassing as before.

Why? Because of the peculiar habits of sound. Most sound waves leave a room by setting up vibrations in the walls, which then transmit those sounds to adjoining rooms. The acoustic tiles this doctor put on his walls prevented the original sound waves from rebounding within *his* room. But they did little to prevent sound from passing through the wall to the reception room.

The doctor's problem was not, as he thought, sound reverberation *within* a room, for which acoustic tiles are indeed an answer. His main trouble, like that of many another physician, was sound transmission *between* rooms.

Medical office walls in which the problem of sound transmission is most acute are shown in color in the floor plan on page 75. The solution here—and the one that should have been used in the office just described is a *barrier* of insulation in the walls between rooms.

When building a new office or

By Allen and Edwin Kramer
**The New York architects who prepared and illustrated this article have a special interest in the design of medical buildings.*

doing a major remodeling job, you can guarantee sound-resistant interior walls, wherever needed, by specifying one of these two general types of construction:

1. *A heavy wall.* Such a wall can be made, for example, of concrete or cinder blocks surfaced with plaster (Fig. 1). This construction forms a five-to-eight-inch barrier that stops sound waves by brute force.

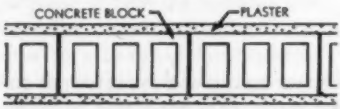


FIGURE 1

2. *A light, double wall.* This will break up the sound waves equally well. Such a barrier often consists of two ordinary stud walls, completely separated from each other. In the air space between, it's advisable to install some insulating material. This can be rigid wall board standing loose between the studs (Fig. 2). Or it can be a flexible rock wool

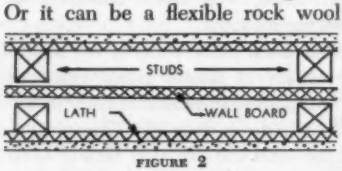


FIGURE 2

blanket woven between staggered studs (Fig. 3). The outside surfaces of such walls are usually lathed and plastered.

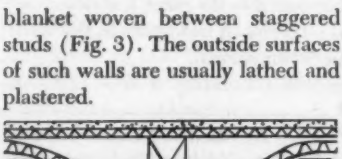


FIGURE 3

But you may not want to remod your present office so drastical just to solve a sound-transmissi problem. In that event, you c soundproof your original walls b either of two methods that are com paratively simple and inexpensive.

¶ Add mass to the walls by a taching plaster board to both wa surfaces. This will increase the tot wall thickness by about three inche Such boards should be separate from the old wall by strips of woo lath.

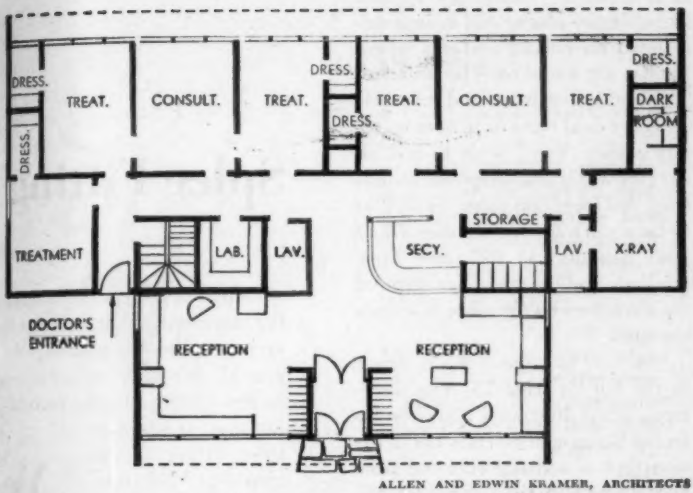
¶ Add a single stud-and-plaste partition on one side of, but no touching, the present wall (Fig. 4) This adds about four inches to th width of the old wall.

FIGURE 4

Even with walls well sound proofed, sounds can steal through doorways into adjacent rooms. To prevent such leakage, doors should be made of solid wood, without panels or hollow cores. As an extra precaution, thin rubber stripping can be attached to the door jambs.

So much for the main problem: sound transmission. Now what about the secondary problem: sound re verberation?

This often doesn't exist in recep tion and consultation rooms, when rugs, draperies, and upholstere



ALLEN AND EDWIN KRAMER, ARCHITECTS

Walls shown in color in this two-doctor office layout embrace some typical noise-problem areas. Here, soundproofing can spare patients both the embarrassment of being overheard in consultation with the doctor and the racket made by children, telephones, toilets, etc.

furniture (as well as waiting patients) help soak up noise. But in treatment rooms and laboratories, sounds are likely to ricochet off the hard surfaces.

To cut down reverberation in these areas, install on the ceilings one of the dozen or so types of acoustic tile. These are made in square sheets of mineral, cork, fiber, and other materials. They're perforated or fissured to sponge up sound waves. Since they differ considerably in cost, effectiveness, and appearance, it's wise to get expert advice before installing them.

Another sound-absorbent materi-

In her soundproofed office, the secretary can be seen but not heard—until she slides open the glass panel.

al is acoustic plaster. It's applied like ordinary plaster and is especially good on curved surfaces where the flat, rigid tiles can't be fastened.

Sound transmission and reverberation are dual hazards in your secretary's office. You'll want to seal off her typewriter and telephone sounds from the reception room, as well as to insure privacy for her discussions with patients. At the same time, you'll do well to spare her some of the din set up by the office machines she uses.

One way to achieve this is shown in the cut on page 75. The secretary's office illustrated gives the effect of being conveniently out in the open but is actually enclosed from floor to ceiling by a curved partition in which are set double glass panels. Above and below the glass, on the secretary's side, the partition is surfaced with acoustic tile. The ceiling of her enclosure is also tiled.

Even when you've taken all the foregoing precautions, it will pay to pay attention to the *sources* of noise.

Take street noises, for example. If they're a problem in your locale, the best bet will be to orient your office rooms away from the street when you build. If it's too late for that, you can, as a compromise, install double-pane windows on the street side. To be effective, these must, of course, be sealed shut. So if you put them in, you may also have to put in air-conditioning.

A source of noise within the office is often the [MORE ON PAGE 187]

Splee Fitting

● Depending on the temper of the argument, there are several synonyms for fee splitting. In a mild discussion it is known as flee spitting. Under increasing strain it is termed splee fitting and fit spleeing. With tempers shorter and tensions higher, it becomes, provocatively, spit fleeing. As a suitable climax to our current discussion of the subject, we here present a fiery defense of splee fitting, cheek by jowl with an equally fiery condemnation. For these totally incompatible points of view, we're indebted to the schizophrenic talents of Theodore Kamholtz, M.D.

Yes

and

No

I Fit Splees

● I spit flees and shall continue to do so. I realize that flee spitting is an allegedly nasty practice sanctioned only by lawyers, who have therefore passed a law making it illegal for anyone else. But, as I see it, the practice of medicine is composed of two things—my skill and a patient. The skill I have. The patient I must find; and when I find him, I'm entitled to squatter's rights.

Of course, I don't demand something for nothing. If necessary, I'll

I *Don't* Fit Splees

● I've been a splee fitter, but I'm not any more. When I first opened an office for the practice of neurosurgery, I had the then common problem: no patients. Nothing I did seemed to fill the empty chasm that was my waiting room.

I tried neon lights with a moving arrow pointing to my door. I hired a butler to greet prospective patients with wet and dry Martinis. But to no avail.

Then one day a G.P. came in

I Fit Splees

drive another doctor to the hospital or scrub down the operating room floor for him. I think it only fair to work for my percentage. Let the surgeon do the cutting, I always say—as long as I get the cut.

If people want to insist that it's not ethical to take the money, however, then it must be just as unethical for me to declare it at income tax time. So I don't declare it. As a matter of fact, it's just as easy for me to take it in cash.

The days before flee spitting were horrible and unjust. Every call came in at 3 A.M. There was always a blizzard to plough through. Where I'd collect 50 cents, the specialist might get $50—and for the same expenditure of time.

Now, thank heaven, it's different. I don't depend on flees from patients any more. Spit flees from specialists are what butter the bread.

I've raised the standards of the profession by sending every patient

Splee Fitting ***(Cont.)***

I *Don't* Fit Splees

with a patient under his arm and demanded a prefrontal lobotomy (for the patient, that is). I was so grateful that I gave him one of my best cigars.

Believe it or not, the next day he returned with a patient under either arm; so I gave him another cigar and a can of beer. Every day thereafter he came with at least two patients. Word got around, and I had doctors from all over town carrying patients to my office.

But soon they weren't satisfied with my beer and cigars. I had to give them the money to buy their own. It was then only a short step to their demand that I give them a percentage of the fee in each case referred to me.

The percentage grew from 5 to 50, and then to 75. For a while, then, I was doing all the craniotomies in the North End.

But at that point, the neurosurgeon across the hall began giving 85 per cent. A fellow who practiced

to Joe the internist, who sends him to Ed the radiologist, who sends him to Dick the gastroenterologist, who sends him to Frank the surgeon. Patients feel great about it. They think I'm the most thorough doctor in the world—which I am. I don't overlook a thing.

I'm a real pillar of the community, too; and all the doctors respect my judgment. If I say a patient has a red hot appendix, my surgeons agree with me—or else. Today, medical opinion hereabouts is uniform, whereas it used to be so divergent as to confuse both patient and physician.

Flee spitting is likewise good business. It has been practiced so successfully that there are no longer any pronounced cycles of prosperity or depression. Somehow, when times are slow, I begin to see more gallstones, more hemorrhoids, and more hernias. Yet when vacations cut our ranks, the incidence of these afflictions dies down.

Flee spitting is, in short, a democratic way of life. It just isn't necessary any more to be a better surgeon, a more skilled operator, a doctor of wider experience or greater training. Anyone can be successful, as long as he knows how to play ball. END

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from a station wagon gave 95 per cent. The only way I could think of to beat the competition was to offer the same plus a free trip to Europe for every patient I received. I figured that with the increasing volume I could break even.

But soon all the G.P.'s were in Europe and I realized that I had created a dangerous public health situation. I was shipping medical talent to Europe faster than the schools could train it.

From that day on, I have fit splees no more. Doctors still go to Europe, but under their own head of steam. Medical practice has again become a stable commodity.

Have I suffered because of this? Not at all. I am now chief neurosurgeon at all seven of the city's hospitals, and I have positively not allowed operating privilges to any other neurosurgeon. I have become regional examiner for the international boards of neurosurgery, and I can say without hesitation that no one in my locality has passed the boards. No neurosurgical resident has received training in my city; and, as chairman of the state licensure committee, I can affirm that no qualified neurosurgeon has passed our examinations.

I am entirely ethical now. I don't even split an infinitive. END

To increase their incomes, many doctors have dabbled in other fields. But the list of fiascos is endless

By Peter S. Nagan

How about a busines

• The pet pastime of physicians these days isn't golf. It's running a business on the side.

Medical management consultants estimate that one doctor in five is currently engaged in a business enterprise. And, they say, the number is growing. These sidelines run the gamut from the manufacture of smoke-eliminating devices to the operation of tung-nut plantations.

Despite the time and energy it requires, a business on the side, *if sound* and *if well run,* offers real financial advantages. For example:

¶ It may be a source of extra income *now,* when taxes and expenses are high and the relatively low yields of "safe" securities just won't do.

¶ It may be the basis of a comfortable income after retirement.

¶ It may produce a substantial, lightly taxed capital gain.

Nevertheless, some doctors would do better to salt their money away in Government bonds or savings banks. Reason: A business sideline isn't *always* a gold mine. There are physicians in every part of the country who can tell of painful losses from what looked like extremely promising situations.

The record shows that some types of business just naturally seem to make a profit. Others are equally prone to fail—though blame for such failure often lies with the doctor himself. Take farming, for example:

Farming is one of the leading out-

sine on the side?

lets for a physician's spare time and cash. This interest stems partly from the fact that many doctors came from the land originally, and partly from the universal desire for "a place in the country."

There are practical inducements, too. Farmers get a break under the revenue laws that permits them to treat the proceeds of certain cattle sales as capital gains, subject to half the ordinary tax rates. And the farmer gets another break on the food he grows; though he is technically supposed to report what he consumes as income, this requirement is ignored more often than observed.

The urge to grow things isn't confined to doctors in rural areas. The environs of every large city are studded with the crops and cattle of physician-farmers. Some are known to have invested as much as $250,000 in their properties.

Any county agent will tell you that doctors use the most modern farming methods known—doubtless because it's their habit to accept and quickly apply the latest fruits of scientific research. Yet few physician-farmers make money from their farming; in some areas less than 4 per cent of the doctor-owned farms pay off financially.

The trouble is that doctors are usually too zealous. As soon as they buy a farm, they begin making major improvements, pouring in much more capital than the farm's short- and middle-run prospects warrant.

One Eastern city physician spent $85,000 for blooded Guernsey cows to stock a farm he'd bought for $20,000. Another $30,000 went for new barns equipped with automatic feeders and milking machines. But feed prices and labor costs were high, while butter prices were low. Result: small losses for the doctor practically every year—plus all the milk he could drink.

An obstetrician in the Carolina tobacco country took over some run-down acreage down the road from the farm on which he was born. He rebuilt the curing sheds at a cost of $7,000, and he now puts a lot of money into the project every year, just to keep it going. His crops have been good, but the market prices haven't covered operating expenses

plus depreciation on the improvements.

Another reason for farms in the red: After the initial enthusiasm has worn off, the typical physician finds that he simply can't spare the time to give his farm the attention it needs.

An M.D. practicing in one of the Middle Atlantic states has so far invested $8,000 in a chicken-raising experiment. His idea: Feed the birds different types of spices, then sell the meat canned, offering a range of flavors. Experts who have looked into it say the scheme has merit; but it needs full-time attention. Meanwhile, it brings in no returns.

In some cases, for the first year or so, the pride of ownership and the pleasure derived from the role of country squire are return enough on a farm investment. But later on the drain begins to tell.

The hope of producing a big money winner has kept a Maryland G.P. tied to horse-breeding through years of red ink. Some of his horses do win—but only small stakes. Prizes, plus the proceeds from the sale of some colts, keep the operation from being a total washout financially. Even so, the G.P.'s losses have averaged around $7,000 a year.

Real Estate Surer?

Luckily, a purely external development has bailed out many such unprofitable operations: The general inflation that has lifted land values has actually permitted some M.D.'s to convert red ink to black.

One physician in the deep South, for example, bought a run-down farm for $10,000 back in 1937. He sank $65,000 into it, converting it from cotton to cattle—and still lost around $1,500 annually. But last year he was able to sell out for $110,000.

What finally took him out of the red, of course, wasn't farming; it was real estate. Real estate operations are as common among doctors as farming. But there's this difference: Real estate is usually more profitable.

Land, apartments, and business properties are fairly dependable income-earners; more than this, they often yield worthwhile capital gains. As a result, doctors have participated in just about every known type of real estate transaction.

A doctor in a New England city paid $11,000 for an old apartment building in a section that was again becoming fashionable. He spent another $22,000 remodeling it. Then, after eighteen months, he sold it—at a $15,000 profit.

Still another M.D. is building $10,000 homes in his native California. The project isn't finished yet, but he seems likely to realize a substantial profit.

Another Western physician has a genius for locating low-priced, heavily-wooded tracts. He sells the timber for a good price, and then gets part of his original investment back by selling the denuded land.

roceeds from the timber have been most all profit, subject to relative-light taxes as long-term capital ins.

Activities Unlimited

After you cover farming and real tate, it's hard to group the busi-ess sidelines of doctors under sim-e headings. Their flyers—past and rospective—are as varied as they're merous. And lack of orthodoxy ems to be characteristic.

To be sure, there are outstanding stances of success in conventional elds. There's the specialist in West irginia who is also president of a rosperous coal company. Though e's a large stockholder, his is no ecure; indeed, he keeps a sharp e on pit operations, sales, and ad-rtising. But for all his commercial tivity, he still stays on top of his edical practice.

Or take the dentist who runs a ickyard in a large Eastern city. e makes the decisions and sees at they're carried out. The opera-on is highly profitable. But the ntist has been heard to say that e demands of the business are rcing him to neglect his practice.

The coal and brick men are rare rds, however. On the whole, few ysicians are involved in retailing manufacturing conventional oducts. The rule-of-thumb seems be: The newer the gimmick, the tter. And new gimmicks have all o often turned out to be unprofita-e.

Take the big-city M.D. who put up $9,000 to help finance a desk-model letter-sealer. It was supposed to be a time-saver with an unlimited market potential; for, after all, the number of desks in the U.S. runs well into the millions. But the venture went broke within a year, even though the physician was serving on the board of directors. It turned out that all but a few of the nation's desk-owners preferred to use their tongues for sealing.

Then there's the doctor who bought a tung-nut plantation in the South—land, buildings, and trees. It looked like a sure-fire proposition, especially since the bulk of the U.S. tung-oil supply can no longer be imported from China.

And, indeed, the market *was* there. But the plants were too delicate, too subject to frost and disease. After losing parts of his crops for several years running, the M.D. has taken in a total of $10,000—at a cost to him of $25,000.

How to Lose Money

The list of fiascos is endless: $12,-000 lost on smoke-eliminators; $5,-500 poured into an aerial photography service; $16,000 sunk into an automobile agency handling one of the less popular makes. The physician who spent $60,000 on a motel that stayed vacant may escape with his shirt—but only because a local housing boom has boosted the value of his land.

Of course, the losses don't all run high. A physician raising chinchillas in an Eastern [MORE ON PAGE 209]

The Interne Shortage ... and You

If it's making extra work for you, you'll want to know how some doctors have met the challenge

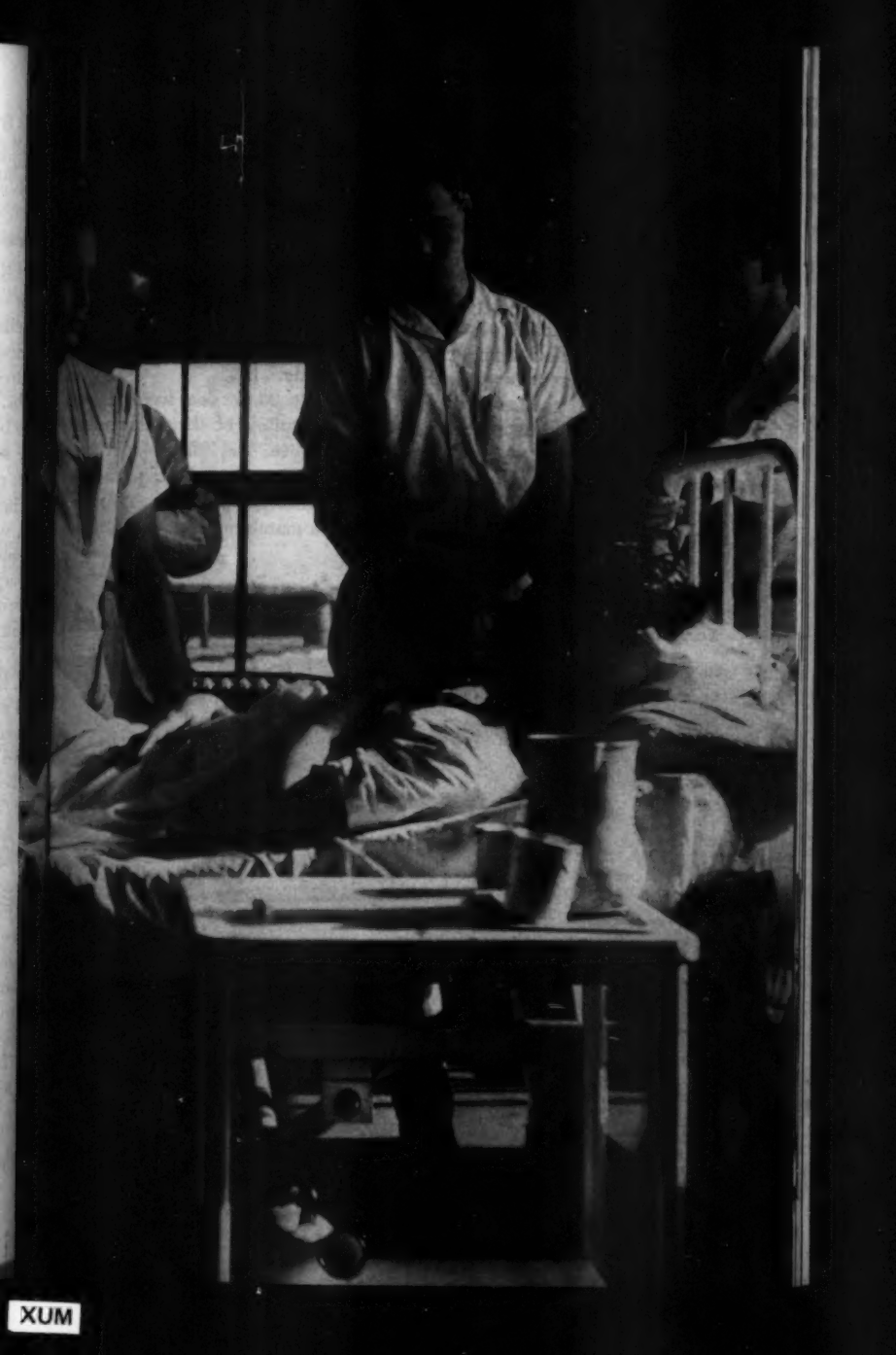
● If this worst interne shortage since internships began has added profitless hours of toil to your hospital practice, at least you needn't feel lonely. Thousands of your colleagues are in the same fix, and more are likely to be.

With the year's harvest of medical school graduates totally absorbed by slightly more than half the nation's internships, the over-all picture is somber. The tubes are squeezed dry, and in order to place a highlight at any dark point you must borrow it from another.

No matter how the available supply may be redistributed in the foreseeable future, too many physicians and surgeons will still have to perform for their hospital patients some or all of the innumerable routine services normally entrusted to internes. Doctors' rounds will continue to be slowed and complicated by histories, physicals, progress reports, dressings, intravenous medications, and tranfusion.

Moreover, the gap between supply and demand will yawn wider. A ten-year

By Don Cameron



trend reached a new high, but *not* a final peak, when 5,564 fledgling M.D.'s last spring found they could choose among 10,414 interneships in 795 hospitals. More than half—2,840 of them—took interneships in 200 teaching hospitals.

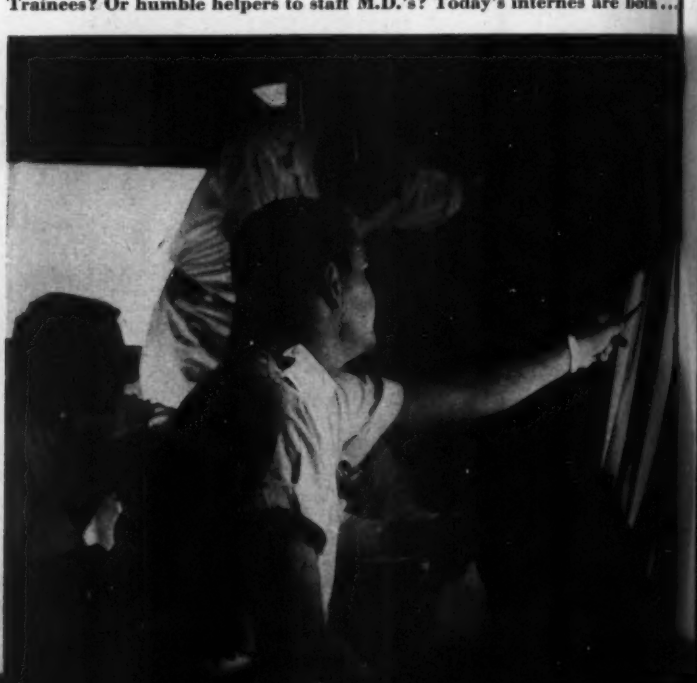
Of 538 non-teaching hospitals, only sixty-seven filled their quotas; 316 got fewer internes than they needed; and 215 got none at all.

The flow of candidates to hospitals affiliated with teaching centers was speeded this year by the new matching plan sponsored by the national medical, hospital, and medical school associations. Under the plan, participating students submitted to the National Interassociation Committee on Interneships confidential lists of favored hospitals, in order of preference. Hospitals listed their choice of applicants similarly. Whenever preferences of student and hospital coincided, a match was made.

Result: 94 per cent were matched with hospitals of their first or second choice, and 92 per cent were the first or second choice of the hospitals that got them.

The matching plan makes no at-

Trainees? Or humble helpers to staff M.D.'s? Today's internes are both...



tempt at equitable apportionment. John M. Stalnaker, the A.A.M.C. director of studies, states frankly: "Popular hospitals will continue to be filled by the plan, and unpopular ones will be left without internes. Each hospital must find its own applicants and make itself attractive to them if it doesn't want to be left out."

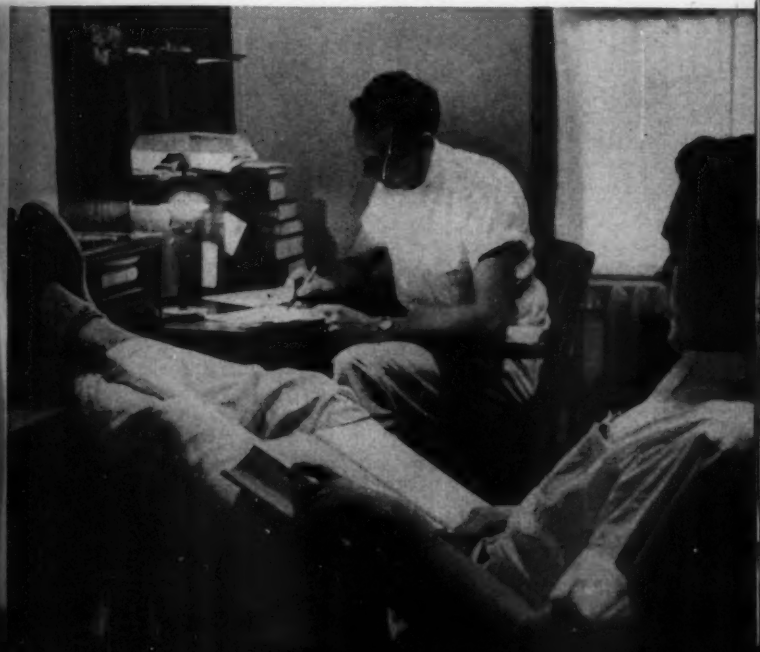
How are staff doctors faring in hospitals that didn't want to be left out, but were? Many of them find their plight somewhat mitigated by one or more of these factors:

¶ Foreign internes are serving in about 2,000 of the 4,850 internships left unfilled by American graduates. An uneven, many-tongued aggregation from fifty lands, they supply much welcome help—and some confusion as well—principally in populous metropolitan areas.

¶ Where medical schools are handy, senior students can often be had to work as externes outside school hours. While histories and reports written by them are considered primarily as exercises, doctors find them useful in many ways.

¶ A number of hospitals, weary

. . . But training and studies still come first, at least in their own minds.



of interne worries, have engaged full-time house physicians. This easy solution, however, has given rise to concern on grounds that it could lead to the permanent shelving of some interne programs and a possible relaxation of local professional standards.

Where none of the makeshifts described is feasible, the attending physician simply works harder. He splits casts, removes sutures, writes charts. He may leave intravenous injections and a few other minor procedures to specially trained nurses. But he can't avoid spending more time on his hospital cases—and less, presumably, on the rest of his practice—than would otherwise be necessary.

Hospital administrators and medical staffmen are girding for fiercer competition as expanded bed capacities and loss of residents to the armed services heighten the demand for internes faster than the supply can possibly increase. Many plan to spend more money and effort than ever before on training programs.

For encouragement they have the examples of some enterprising hos-

Big teaching hospitals attract plenty of internes to help with dressings . . .

pitals in the hard-hit small-to-medium-size class. Despite the allure of the big teaching institutions, a few of these hospitals are getting a fair share of internes by hard work and careful planning.

However, the non-teaching hospital of fewer than 250 beds usually is at a disadvantage in the competition, unless it is prosperous beyond the average. Says Dr. Edward H. Leveroos, associate secretary of the A.M.A. Council on Medical Education and Hospitals:

"Only hospitals offering a high quality of interne training can expect preference. That eliminates hospitals that still regard the interne as an inexpensive source of medical services. Good training is costly. The hospital that fulfills its obligation to its internes will get its money's worth, but it *won't* get cheap help."

For some time the A.M.A. council has been reiterating a toothless recommendation—frequently disregarded by teaching hospitals—that interneships be limited voluntarily to one for each fifteen to twenty-five beds. For nearly two years the council has also been mulling over

. . . and labwork; but elsewhere, staff M.D.'s may have to do these chores.

a more radical plan for correcting the lopsided distribution. This would provide that hospitals be approved henceforth *for specified numbers of interneships* based on bed capacities, instead of receiving blank-check approval for as many as they wish.

But doctors saddled with internes' work shouldn't count too heavily on this possibility, for two reasons:

1. Students of medicine and their deans, wanting to preserve freedom of choice as far as possible, are opposed to anything that smacks of interne rationing.

2. Even if reasonable limitati... were applied to hospitals, there ... wouldn't be internes enough to ... around.

Figure it any way you want: T... most attractive bidders are going ... get most of the graduates for a l... time to come.

Your hospital will qualify as ... attractive bidder, Mr. Stalnaker w... unteers, if students can rate it hi... on most of these points: prest... training, staff personalities, af... tion with teaching institutions, ... the outlook for residencies and st... appointments.

Is your hospital short of competent help for such things as evening round...

Living conditions and stipends may be important, especially in the case of married internes. But large stipends (some hospitals are offering $250 a month and more) will *not* attract internes unless other favorable factors are present.

If the law of supply and demand has elevated the American medical graduate to a position of unprecedented independence, it has done scarcely less for the foreign interne. As the only available substitute for the native product (and available in sufficient numbers to make a respectable difference), he also is the object of ever keener bidding.

About 500 largely hand-picked graduates of medical faculties in Latin America, Europe, the Near East and the Orient arrive annually in the United States to spend a year or more in interneships. They come, with the blessing of the Department of State, mainly through the operations of several voluntary agencies, which regard their work primarily as a contribution to international goodwill and understanding. Among the more active agencies are the China Institute in America, the Institute of International Education,

. . . and progress notes? A revitalized interne program can bring some relief.

and the Near East College Association, all with headquarters in New York City.

A recent development that has attracted wide attention is the experiment of Dr. and Mrs. Hilton S. Read, of Atlantic City, in bringing over top-ranking students from schools in West Germany. While the project is barely past its first year, and still is limited to a few New Jersey hospitals, plans are being made to expand its coverage in future years.

Advertisements in medical journals and letters to medical school deans bring other graduate students from England, Scotland and Ireland. Sometimes, through contacts abroad, doctors or hospital superintendents will make their own arrangements to bring internes from far-flung points on the globe.

A good many of the exchange internes—notably those from the English speaking countries—are well trained and able. Others present problems. Says the chief of interne training of a 250-bed hospital that has had to rely almost entirely on candidates from other lands:

"The average foreign interne,

Interne's pay, averaging under $100 a month, still means coke dates . . .

ignorant of our customs and with the merest smattering of English, is apt to be only a not-very-capable pair of hands during his first year. More often than not, his training hasn't been up to our standards. And he may consider himself an individualist in the old tradition, with the result that he has difficulty getting used to teamwork.

"But the intelligent one eventually learns the customs and overcomes his other shortcomings. After a year he's usually doing all right. Trouble is, as a rule, that's when he must return to his own country."

Besides these "lend-lease" internes, something like 1,500 foreign physicians—permanent U.S. residents but not yet licensed to practice—now are serving interneships principally in the smaller non-teaching hospitals. Most of them practiced in their own countries before coming here as immigrants or displaced persons.

The medical examining boards of twenty-two states and the District of Columbia make American interneship or residency a required preliminary to licensure of foreign-trained physi- [MORE ON PAGE 201]

. . . and sock-washing; but twice that won't draw him to training-poor towns.

WHAT THE ETHICS CODE SAYS ABOUT

Physician-Patient Relations

• Most doctors seem to find the A.M.A. ethics code a bit too formidable for leisure-time reading. Yet there's a surprising amount of information in the code that applies directly to their day-to-day problems. Here, for example, are five questions of conduct that often beset physicians in their relations with patients. Do you know the correct answer to each? All quotes are from the Principles of Medical Ethics.

Other than in an emergency, when must a doctor respond to a request for his help?

"... whenever temperate public opinion expects the service."

Having taken a case, how much notice must a doctor give before withdrawing from it?

Enough advance notice "to allow [the patient or his relatives] to secure another medical attendant."

What medicines must a physician not dispense or prescribe?

". . . secret medicines . . . of which he does not know the composition . . ."

Under what conditions may a doctor reveal a privileged communication?

(1) When it is "required by the laws of the state" or (2) when it is necessary "to protect a healthy person against communicable disease."

When may a physician play down the seriousness of an illness?

"The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family."

Life Insurance: How Much Is Enough?

A means of covering basic needs without plunging in over your head

● Want a rule of thumb to tell you how much life insurance you need? Then just inquire around.

One well-meaning adviser will say, "You should carry life insurance equal to five times your annual earned income." Another will say, "The amount you put into life insurance should equal 10 per cent of your total earned income." From still another you'll hear, "You should carry enough insurance to give your wife a life income equal to half your current net income after taxes."

Any one of these rules might do if it could always be applied. The trouble is, none of them takes into account the individual variations (such as age, health, income, and number of dependents) that make one man's needs so different from another's.

Moreover, general rules like these often call for larger premium commitments than the average man can afford. For example, to meet the requirements of the last formula above, a young doctor netting, say, $1,000 a month might well [illegible] himself paying out more than [illegible] 500 a year in premiums.

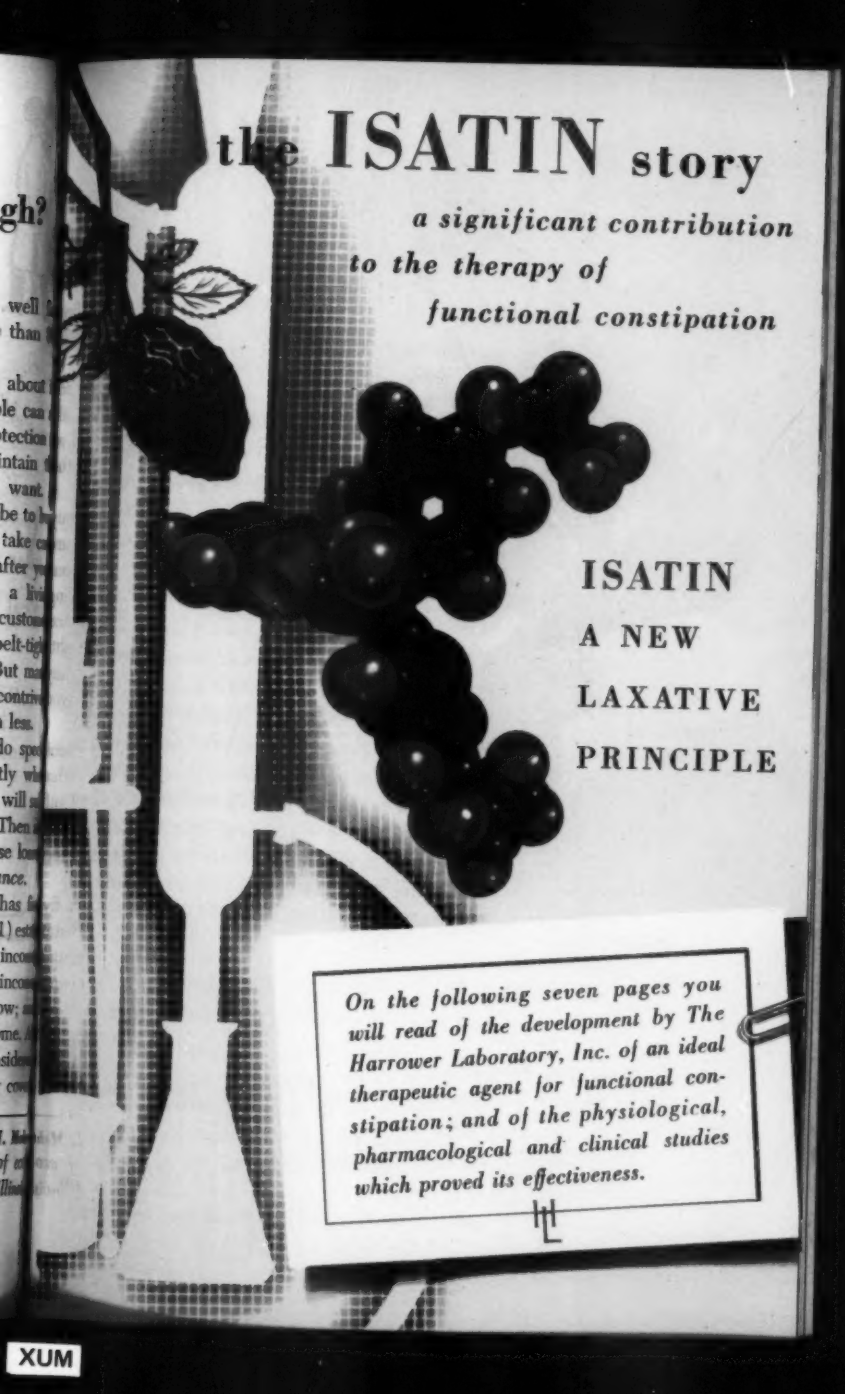
One of the sad truths about [illegible] surance is that few people can [illegible] ford to buy as much protection [illegible] they need and still maintain [illegible] standard of living they want. [illegible] *practical* goal, then, may be to [illegible] just enough insurance to take [illegible] of your family decently after [illegible] death. This won't assure a liv[illegible] standard the family is accustom[illegible] to; in fact, it will call for belt-tig[illegible] ening all along the line. But m[illegible] an insurance program contri[illegible] haphazardly provides even less.

Now here's what you do spe[illegible] fically: First, decide exactly wh[illegible] financial losses your family will s[illegible] fer because of your death. Then [illegible] range to guard against these los[illegible] *in the order of their importance.*

The average physician has fi[illegible] basic life-insurance needs: (1) est[illegible] clearance; (2) readjustment incom[illegible] (3) dependency-period incom[illegible] (4) life income for his widow; a[illegible] (5) his own retirement income. A[illegible] these needs must be consider[illegible] when determining necessary cov[illegible]

By Robert I. M[illegible]

**The author is professor of e[illegible] nomics at the University of Illi[illegible]*


the ISATIN story
a significant contribution
to the therapy of
functional constipation
ISATIN
A NEW
LAXATIVE
PRINCIPLE
On the following seven pages you will read of the development by The Harrower Laboratory, Inc. of an ideal therapeutic agent for functional constipation; and of the physiological, pharmacological and clinical studies which proved its effectiveness.

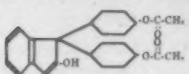
ISATIN

SCIENCE DISCOVERS WHAT NATURE HAS KNOWN

From prunes, Nature's own laxative food, has come the answer to functional constipation.

In 1950, after 3 years of intensive investigation, a Harrower research team isolated and identified a diphenyl isatin as the principal laxative component of prunes.[1] A synthetic analogue of the isatin identified in prunes was then evaluated. Like Nature's Isatin, it was found to supplement the colloidal and emollient effects of prunes by gently stimulating peristalsis, and did so without any undesirable side effects.

The formula of this ISATIN is:



Diacetylhydroxyphenylisatin

Additional pharmacological, physiological and clinical investigations over a 2 year period have shown that:

This **ISATIN** is not absorbed; it is eliminated 100% in the feces.

This **ISATIN** is effective in small dosage.

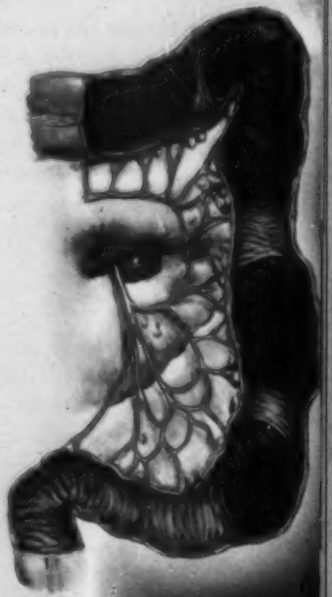
This **ISATIN** gently stimulates peristalsis; it does not irritate.

THE PHYSIOLOGY OF FUNCTIONAL CONSTIPATION

The basic physiological abnormality in functional constipation is *subnormal peristalsis*. The musculature of the constipated colon is thinned and atonic and cannot be sufficiently activated by the reflex stimulation produced by the intestinal contents. Regardless of their bulk or consistency, the intestinal contents alone cannot stimulate sufficient colonic motility. Adequate propulsion can be induced only by therapeutic use of an activating principle.

RATIONALE OF THERAPY

These physiological facts have long been recognized. The problem has been to discover a safe activating agent. Until the isolation and identification of ISATIN by The Harrower Laboratory, Inc., all known agents, such as phenolphthalein and cascara, produced undesirable, harmful side effects. *ISATIN, however, provides the essential gentle stimulation of peristalsis without any undesirable side effects.*



PHARMACOLOGY

ISATIN is the only known safe and effective peristaltic stimulant. The following chart of comparative pharmacology shows its definite and distinct superiority over other agents.

COMPARATIVE PHARMACOLOGY

	ISATIN*	PHENOLPHTHALEIN	CASCAR
PHYSIOLOGICAL ACTIVITY	Stimulates intestinal mucosa[2]	Irritation of colon, increasing[3] frequency of contraction rings	Irritation of co increasing[4] fre of contraction
INTENSITY OF ACTION	Mild[5]	Medium[3]	Medium[4]
SIDE EFFECTS	No side[11] effects	Entero-colitis, dermatitis and other allergic and hemorrhagic tendencies[4]	Melanotic pigm of mucosa[4] Nausea and gri
ABSORPTION	None[7]	Partial (about 15% in intestine)[3]	Partial, in inte
EXCRETION	Feces[7]	In urine conjugated with sulfates[3] Partially unchanged in large doses	In urine as glu in milk unchan Feces
DEVELOPMENT OF TOLERANCE	None[8]	With continued dosage[6]	With continued
DOSAGE	5 mg.[9]	60 mg.[10]	300 mg. (Po-Ea

*Diacetylhydroxyphenylisatin

FORMULATION OF PRULOSE COMPLEX

ISATIN, the new laxative principle which activates physiologically and is pharmacologically safe, has been combined with prune concentrate and moist bulking agents to produce the therapeutically rational laxative—**PRULOSE COMPLEX.** Extensive clinical studies have shown **PRULOSE COMPLEX** to be an ideal agent for the correction of functional constipation.

CLINICAL EVALUATION

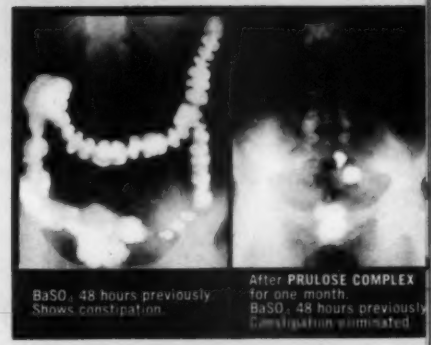
A recently published clinical evaluation[11] of **PRULOSE COMPLEX,** Isatin-activated moist bulk, showed that colonic motility was considerably enhanced in all patients without any undesirable side effects.

One hundred eighty barium X-ray studies were performed. The following two cases illustrate the results of therapy with **PRULOSE COMPLEX,** as evaluated by X-rays.

Case	Sex	Age
R.I.	F	54

Chief Complaint
Marked prolonged constipation; obesity.
Duration—life-long.
Therapy **PRULOSE COMPLEX**

Results
Excellent.
Defecates regularly; normal stool; "most grateful".



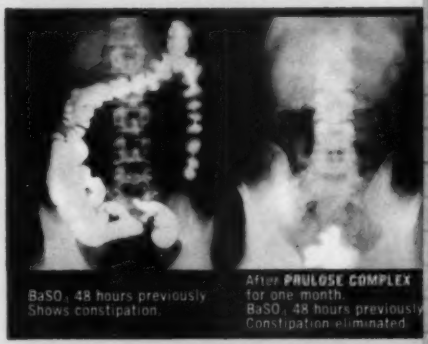
Constipated patients who had ingested barium 48 hours before X-ray examination showed in these films that the barium was distributed through the colon, with a tendency towards stasis in the cecum and transverse colon.

The same constipated patients, after receiving **PRULOSE COMPLEX** for one month, when X-rayed again 48 hours after the ingestion of barium, showed that the barium was either already evacuated or confined to the distal portion of the large intestine.
This indicated that normal bowel tonicity and motility had been restored. The medication proved to be clinically and roentgenologically effective, and no untoward effects were observed.

Case	Sex	Age
L.E.	M	21

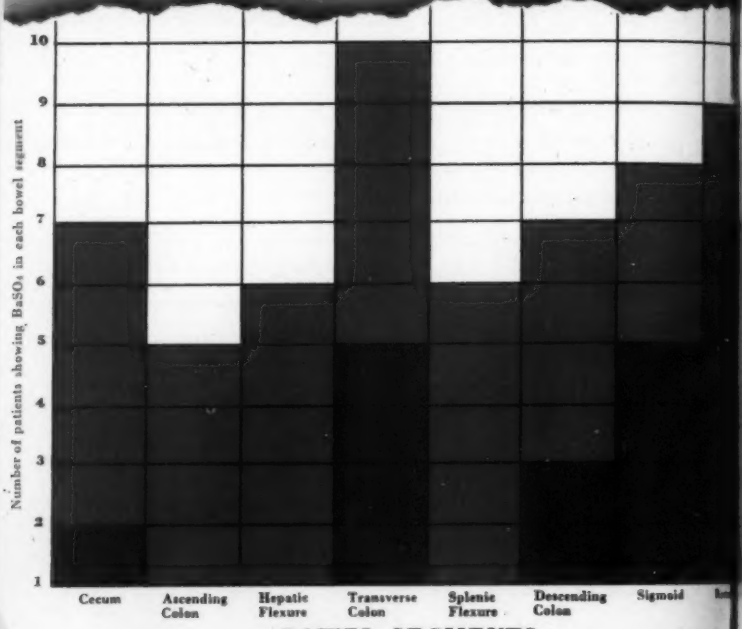
Chief Complaint
Constipated and "tired".
Due to chronic illness of ten years' duration.
Therapy **PRULOSE COMPLEX**

Results
No longer constipated.
Gained 8 lbs. in weight.
No longer tired.



The following graph illustrates the number of patients whose X-rays showed barium in each large bowel segment. The red indicates the number of patients with barium in each bowel segment before treatment with PRULOSE COMPLEX. The blue illustrates the markedly decreased number of patients showing barium in each bowel segment after one month of PRULOSE COMPLEX therapy.

PRULOSE COMPLEX increased colonic motility so that most of the barium was propelled into the distal bowel segments or evacuated completely.



This clinical study proved that PRULOSE COMPLEX Isatin-activated moist bulk, provides the stimulation of peristalsis necessary to correct functional constipation and does so without any undesirable side effects.

PRULOSE® COMPLEX, *moist bulk*

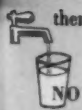
activated with Isatin, the new laxative principle, is available in both liquid and tablet dosage.

Both **PRULOSE COMPLEX** dosage forms are the only Isatin-activated moist bulk laxatives.

Both **PRULOSE COMPLEX** dosage forms provide pharmacologically safe and clinically effective therapy for functional constipation.

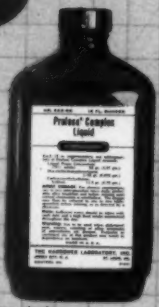
Both **PRULOSE COMPLEX** dosage forms may be used safely in all age groups. The flavorful liquid is ideal for pediatric and geriatric patients.

DOSAGE: 1 or 2 tablespoonfuls of liquid, or 3 or more tablets, with a full glass of water, twice daily, preferably after breakfast and before retiring, until normal elimination is established. The dosage may then be reduced.



NOTE: Sufficient water should be taken with each dose and a high fluid intake maintained throughout the day.

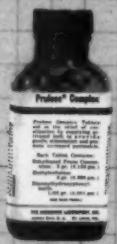
FLAVORFUL LIQUID



Each 15 cc. (approximately one tablespoonful) of **PRULOSE COMPLEX LIQUID** *contains:*

Liquid Prune Concentrate (28% solids)	52 gr. (3.37 gm.)
Diacetylhydroxyphenylisatin	1/32 gr. (0.002 gm.)
Carboxymethylcellulose, Sodium	11.5 gr. (0.75 gm.)

CONVENIENT TABLETS



Each **PRULOSE COMPLEX** *Tablet contains:*

Dehydrated Prune Concentrate	2.0 gr. (0.13 gm.)
Diacetylhydroxyphenylisatin	1/65 gr. (0.001 gm.)
Methylcellulose	6.0 gr. (0.39 gm.)

The new therapeutic agent, **PRULOSE COMPLEX**, offers these distinctive advantages:

1. A new laxative principle, Isatin, which has been proven to be physiologically active, pharmacologically safe and clinically effective.

2. A therapeutically rational approach to the problem of normalizing the function of the constipated colon.

Only

ISATIN

a. **gently and mildly stimulates subnormal peristalsis.**

b. **is excreted 100% in the feces, with no absorption. Its action is limited to the colon.**

c. **is free of all undesirable side effects.**

Only

PRULOSE COMPLEX

combines Isatin-activated moist bulk with a natural prune concentrate base.

Only

PRULOSE COMPLEX

provides safe activation—without irritation—without side effects.

MEMO

On these 8 pages we have presented the story of Isatin, the new natural laxative principle available only in **PRULOSE COMPLEX**. *We would like to provide you with a clinical supply of the tablets and the new flavorful liquid for a trial in your own practice.*

Simply write "ISATIN" on a prescription blank or your stationery and send it to The Harrower Laboratory, Inc. for your supply of **PRULOSE COMPLEX LIQUID** *&* **PRULOSE COMPLEX** *Tablets and additional reprints on Isatin.*

the Harrower Laboratory inc.

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age. Let's take a further look at each of them:

1. *Estate clearance:* A person's estate is always worth less after his death than just before it. For one thing, the act of dying is expensive, what with funeral costs usually coming hard on the heels of a costly final illness. There may also be some debts of the deceased to clear up. And, of course, if the estate is large enough, there will be death taxes to pay.

2. *Readjustment income:* Even if a widow is an efficient money manager, she may find it hard to cut expenditures sharply right after her husband's death. So try to provide at least a six-month continuation of the level of income that she's accustomed to. This will enable her to beat an orderly retreat to a lower economic level without undue anguish and without the hasty liquidation of disposable assets.

3. *Dependency-period income:* When there are growing children to support, it may be doubly hard for a widow to make ends meet. Yet if she has to work to support her family, they'll be deprived of valuable home guidance. One of the main goals of any life insurance program, then, should be to take care of the family at least until the children have been graduated from high school.

4. *Life income for the widow:* A fresh set of financial problems crops up after the children have become

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'Carbo-Resin' Thera

New recipe book helps keep patients on 'Carbo-Resin'

A new *unflavored* 'Carbo-Resin,' which can be incorporated in cookies, puddings, fruit juices, and the like, is now available. Printed recipes giving complete directions for preparing a variety of tasty dosage forms in the home can be obtained from the Lilly medical service representative or direct from Indianapolis upon request.

CAUTION: Only unflavored 'Carbo-Resin' is suitable for incorporation in recipes.

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- Permits more liberal salt intake, enhances palatability of diet
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Carbo-Resin

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self-supporting. It's not at all certain that the widow will be able to support herself then, since job opportunities for inexperienced, middle-aged women are limited. Nor is it desirable to saddle children with the support of their mother. Hence the importance of having enough insurance to give her a minimum life income.

5. *Retirement income:* Now suppose, as is likely, that premature death doesn't strike the family breadwinner after all. He'll then need to have figured out a retirement plan that will afford old-age security—in the face of high taxes and low interest yields.

Few physicians accumulate enough capital to provide a livable income from interest alone when they reach 65. They must draw on capital. But the capital must be liquidated systematically so it doesn't peter out before the old man does. Often a good way to do this is to buy, for a lump sum, a lifetime-income annunity.

Only after these five basic needs have been provided for should others be considered. Some doctors will be able to include a plan to finance their children's college education. Some will include emergency funds to offset unusual cash demands. Others will take out life insurance on other members of the family. But under no circumstances should these "extras" be bought at the expense of more important coverage.

Remember that few men can afford to cover even their basic insurance needs in full. So, even after you've assigned a value to each need, you'll probably have to compromise somewhere.

Take, as an example, a typical young doctor. Contrast his *needs* and his *wants*:

Fred Jackson is a 35-year-old G.P. who nets about $12,000 a year. His wife, Mary, is 31; he has two children, 5 and 3. He's decided he can afford to spend $1,000 a year for life insurance and retirement and he estimates his *minimum* needs this way:

1. Estate clearance fund—$12,000 (including $10,000 to retire the mortagage on his home).

2. Readjustment income—$300 a month for the six months immediately following his death.

3. Dependency-period income—$250 a month for the next thirteen years, and $200 a month for two years after that. [MORE→

"So that's a germ! I'd always thought of them as being much smaller."

4. Life income for Mary—$150 a month after the dependency period ends.

5. Retirement income—$225 a month while both he and Mary are alive; $150 a month for life to the survivor upon the death of either.

But Fred Jackson finds he can't buy even that much protection for $1,000 a year. A combination of policies suggested to him by an insurance agent—comprising $52,000 worth of insurance paid up at age 65 and $21,000 worth of ordinary-life—would cost him more than $1,800 a year. Such relatively high-premium plans, the agent points out, are necessary for him to build up the desired cash values for retirement.

Trimming Costs

He feels he doesn't want to sink an extra $800 a year into premiums, so all he can do is modify his objectives—at least for the time being—and buy insurance of the less expensive type. Since the first four parts of his program can't be trimmed without risking harm to his dependents, he's obliged to sacrifice some of his retirement allowance. He does this by buying $43,000 worth of one-year term insurance (renewable) and $30,000 worth of ordinary-life. His retirement fund from this will amount to only around $90 a month; but he'll approximate a $1,000-a-year outlay without cutting down his family's protection.

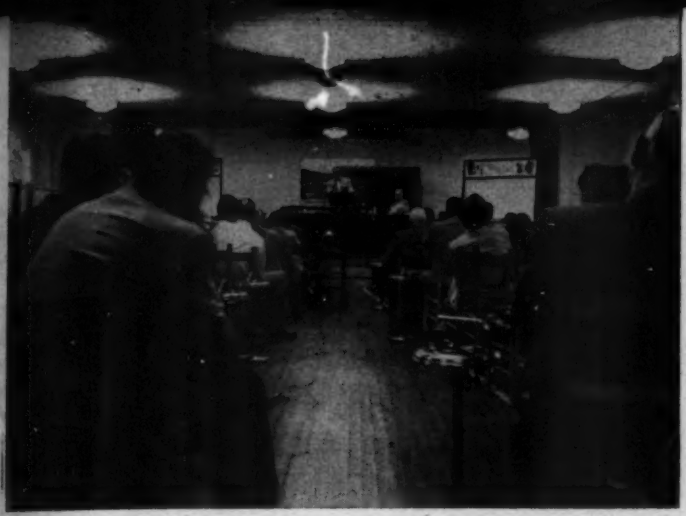
In the years ahead, as his wife's life expectancy decreases and as the unpaid balance of his mortgage reduced, Dr. Jackson may elect to discontinue some of his yearly renewable term-insurance. In this way he can maintain a level premium despite the necessarily higher rate he must pay for term insurance as his age increases.

Chances are, however, that he'll prefer to pay the higher premium and continue the same amount of insurance in force. He can reasonably assume that his income will have increased by then so that he'll be better able to afford it. And with price levels continually rising, he can *not* assume that he'll do right by his family in reducing coverage later in life.

Of course, he must also ponder ways to bolster his retirement fund. So as time goes on, he may decide to convert some of his policies to others that will have greater cash value when he's 65. Or he may prefer to rely on other investments to bolster his retirement fund.

The point is that the problem faced by our hypothetical Fred Jackson is a real one that hits just about everybody who decides to draw up a detailed life insurance plan. It's a rare person who doesn't have to trim his "minimum" program after he's learned what it will cost.

Certainly no doctor wants to leave his dependents penniless when he dies. Neither does he want to put so much money into insurance premiums that he denies his family a comfortable standard of living while he's still around.



Rx for Too Many Medical Meetings

Omaha doctors have lowered the quantity and raised the quality of their meetings in a big way

● Until they found a way recently to cut their almost incessant round of medical meetings, Omaha, Neb., doctors were seeing far too much of each other and not nearly enough of their patients and families.

In fact, before they decided to do something about their problem, they made a startling discovery: There was at least one meeting of Omaha doctors almost every weekday or night in the year.

Were Omaha's 450 practicing physicians more meeting-bound than those in similar communities? Probably not. The fact was simply that Omaha, with its 250,000 population, its nine hospitals, its two medical colleges, its many specialty societies, and its innumerable doctors' committees, has its full quota of the meeting-breeders that make doctors run.

Run ragged by organizational obligations, physicians finally began to ask themselves, "Is this meeting

By James C. Fuller

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Each an active antirheumatic in its own right, salicylate and para-aminobenzoic acid—as combined in Pabalate—produce a synergistic analgesia that can provide 24-hour pain relief for patients with rheumatic affections—even for many who are refractory to salicylates alone. Pabalate is remarkably free from gastric irritation or systemic reactions. Each Tablet, or each teaspoonful of chocolate-flavored Liquid, contains 5 gr. sodium salicylate U.S.P. and 5 gr. para-aminobenzoic acid. Also available as Pabalate-Sodium Free, employing ammonium salicylate and the potassium salt of para-aminobenzoic acid.

REFERENCES: 1. Dey, T. J. et al.: Proc. Staff Meetings Mayo Clinic 21:497, 1946. 2. Hoagland, R. J.: Am. J. Med. 9:272, 1950. 3. Smith, R. T.: J. Lancet 70:192, 1950.

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necessary?" And their answers became more and more hard-boiled. Result: The less conscientious ones skipped all meetings on their schedules except those that might aid them personally or keep them from losing staff appointments.

The chief casualty of this hooky-playing was the Omaha-Douglas County Medical Society. Attendance at its monthly meetings dropped to a mere twenty-five members or so, or less than 7 per cent of its 400-odd total. For as many as fifty members to turn out was cause for rejoicing.

By the end of 1950, the situation had become so acute that retiring President Maurice Howard bluntly warned members of the society that they had a thoroughly "stagnant" organization and had better do something about it in a hurry. For its decline, he blamed forced attendance at monthly hospital staff meetings and the competing meetings of specialty and other groups.

When the Omaha campaign for fewer meetings got under way soon afterward, its most immediate goal was the revival of the medical society. Here's what happened:

A year ago last spring, Dr. Lynn Thompson, one of the two men who sparked the campaign, learned that Denver, Col., doctors were trying to cut down hospital staff meetings. To Dr. Thompson, an anesthesiologist and faculty member at the University of Nebraska College of Medicine, the Denver campaign suggested a promising way for Omaha M.D.'s to solve their initial problem: *viz.*, how, in the solid wall of doctors' meetings, to make the first crack?

But he was aware of a possible hitch: Didn't hospitals have to hold at least twelve staff meetings a year to retain their status as approved institutions? Most doctors apparently thought so. And the constitutions of some Omaha hospitals made meetings compulsory.

To get an official ruling, Thompson queried the American College of Surgeons. He was told by the A.C.S. that if other hospital standards are kept at high levels, four staff meetings a year are considered adequate.

This was the green light he had been hoping for. Once he'd been given it, he enlisted the help of Leroy W. Lee, head of his medical school's urology department.

Together, they buttonholed colleagues and within a few days collected the signatures of over 200 Omaha physicians on a petition to the medical society. It called for action on staff-meeting reductions.

The two jubilant campaigners had made a not unexpected discovery: In their own words, "Doctors, like other people, dislike constant meetings. In Omaha, we found this feeling to be universal."

Three months later, as co-chairmen of the society's new anti-meetings committee, Drs. Thompson and Lee were ready with their plan. Each hospital was to be given the opportunity to decrease its general

staff meetings from twelve a year to four.

Not only did society members unanimously approve the idea, but all nine Omaha hospitals promptly agreed to try it out. One of these had reservations, but it was still willing to cooperate. Thus, in one move, seventy-two meetings a year were erased from the datebooks of Omaha physicians, many of whom were members of several hospital staffs.

"Hospital administrators actually welcomed our plan," say Thompson and Lee. "For reducing the meetings to a quarterly basis eased their work in planning dinners and programs for their medical staffs."

Even more noteworthy was the stimulating effect on the medical society. At its first meeting after the plan began operating, more than half the approximately 400 members attended, some of them for their first time in a decade. With four or five times as many active members as before, the society has naturally been able to improve its programs. And thanks to more interesting meetings, the bumper turnout continues.

Now that they've made their first radical cut in meetings and put new life into the medical society, Omaha doctors are confident that their new philosophy will prove catching. As Drs. Thompson and Lee see it:

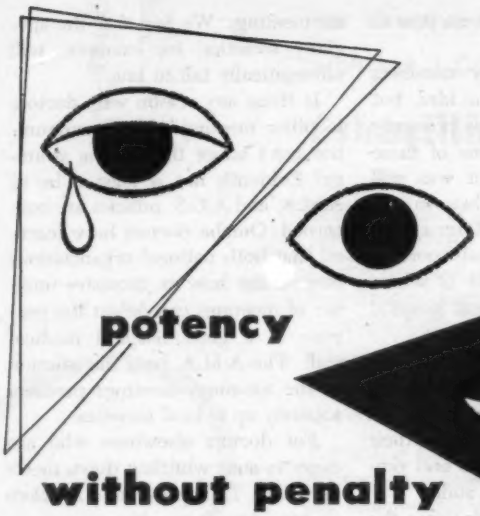
"The effects of this program will be increasingly far-reaching as members of other local medical groups see the advantages of fewer and better meetings. We feel that the specialty societies, for example, will automatically fall in line."

Is there any reason why doctors in other meeting-ridden communities can't adopt the Omaha strategy? Evidently not, at least as far as A.M.A. and A.C.S. policies are concerned. Omaha doctors have learned that both national organizations now realize how an excessive number of meetings can defeat the purpose of a good hospital medical staff. The A.M.A. puts the solution of the too-many-meetings problem squarely up to local societies.

For doctors elsewhere who are eager to start whittling down meetings, Drs. Thompson and Lee have an encouraging word:

"It's not hard to accomplish such a program. All you need is one or two physicians who really want to get the ball rolling." END

"Oh, Doctor . . ."



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Neohetramine is an antihistamine of proved tolerance that enables the physician to prescribe dosages for all ages with the widest latitude of professional discretion. Virtual freedom from sedation permits administration by day as well as night.

Neohetramine, extremely effective in a multiplicity of allergic phenomena in all age groups, has been accepted for admission to New and Non-Official Remedies of the Council on Pharmacy and Chemistry of the American Medical Association.

Neohetramine hydrochloride — Brand of Thonzylamine Hydrochloride — N,N-dimethyl-N'-p-methoxybenzyl-N'-(2-pyrimidyl) ethylenediamine monohydrochloride.

Tablets — 25, 50, and 100 mg. in bottles of 100 and 1000.
Syrup — 6.25 mg. per cc. in bottles of 1 pint.
Cream 2% — in water-miscible base in collapsible tubes of 1 oz.

Neohetramine®

exceptional tolerance → wide dosage range → notable activity

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Some things you'll want to know about

Those Withholding Taxes

• It's no news that the hard-pressed physician is today a tax collector as well. As if he didn't have extracurricular problems enough with his own income and property taxes, the Government has saddled him with this triple-threat burden besides:

1. He must make Solomon-like decisions as to which of his assistants are bona fide employes and which of them are independent contractors.

2. He must calculate, withhold, and deposit the income taxes and Social Security contributions of each of his employes, as well as the payroll taxes for which he himself is liable.

3. He must fill out and file as many as nine different forms—some monthly, some quarterly, some annually.

You, as one of the victims, are by now familiar with most of the Federal withholding and filing regulations that apply to you. But there are still some facts of the law that it may help you to know more about and to have available in simple, organized form.

The law holds a doctor responsible for withholding and filing only when he meets the definition of an employer. For tax purposes, the Bureau of Internal Revenue defines an employer as one who:

1. Has the power to hire and fire;
2. Bears financial and professional responsibility for the acts of his staff;
3. Specifies the way in which work should be done, as well as its end result;
4. Furnishes the equipment and space used by the staff.

By this definition, the doctor's secretary, his nurse, and any full-time technician are employes for whom taxes must be withheld. But his auditor and the laboratory technician who works for a job-fee are independent contractors.

All too often, though, there are borderline cases of staffers or workers who might fall into either class.

Take, for example, the physician who has engaged an assistant to help with his practice. The junior man, a licensed M.D., is qualified to treat patients on his own. But this is not a partnership, for the assistant is paid a salary.

You might think that the senior physician has no responsibility to withhold; for, after all, doctors usually pay their own income taxes di-

By Peter S. Nagan

pressure

W

he pr

em

cau

diet

work

worry

emotional disturbance

pressure, diet, work, worry,

emotional disturbances, visceroneurosis

cause ***Nervous Indigestion*** . . .

BENTYL

offers effective, comfortable, sustained relief from pain, cramps, general discomfort due to functional gastrointestinal spasm. In clinical studies[1, 2, 3] BENTYL gave gratifying to complete relief in 308 of 338 cases, yet was ". . . virtually free from undesirable side effects."[3]

EACH CAPSULE OR TEASPOONFUL SYRUP CONTAINS:

BENTYL.....**10 mg.**
For safe, double-spasmolysis

BENTYL.....**10 mg.**
with **PHENOBARBITAL**...**15 mg.**
When synergistic sedation is desired

Dosage—ADULTS: 2 capsules or 2 teaspoonfuls syrup 3 times daily, before or after meals. If necessary, repeat dose at bedtime. IN INFANT COLIC: ½ to 1 teaspoonful syrup 3 times daily before feeding.[4]

Merrell
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1. Hock, C. W.: J. Med. Assn. Ga. 40:22, 1951 • 2. Hufford, A. R.: J. Mich. St. Med. Soc. 49:1308, 1950 • 3. Chamberlin, D. T.: Gastroenterology 17:224, 1951 • 4. Pakula, S. F.: Postgrad. Med. 11:123, 1952—*Trade-mark "Bentyl" Hydrochloride*

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KAPSEALS® TAKA-COMBEX

Each Kapseal contains:

Taka-Diastase (Aspergillus Oryzae Enzymes)	2½ gr.
Vitamin B_1 (Thiamine Hydrochloride)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Vitamin B_6 (Pyridoxine Hydrochloride)	0.5 mg.
Vitamin B_{12} (Cyanocobalamin)	1 mcg.
Pantothenic Acid (As the Sodium Salt)	3 mg.
Nicotinamide (Niacinamide)	10 mg.
Vitamin C (Ascorbic Acid)	20 mg.
Liver Concentrate N.F.	0.17 Gm.
Liver Fraction No. 2 N.F.	0.17 Gm.

In bottles of 100 and 1000.

ELIXIR TAKA-COMBEX

Each teaspoonful (4 cc.) contains:

Taka-Diastase (Aspergillus Oryzae Enzymes)	[illegible]
Vitamin B_1 (Thiamine Hydrochloride)	[illegible]
Vitamin B_2 (Riboflavin)	[illegible]
Vitamin B_6 (Pyridoxine Hydrochloride)	[illegible]
Pantothenic Acid (As the Sodium Salt)	[illegible]
Nicotinamide (Niacinamide)	[illegible]

In 16-ounce bottles.

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rect, and Congress specifically exempted doctors from compulsory Social Security. But such exemptions apply only to "independent" professionals. The fact that the senior physician meets the four criteria of an employer means that he has to withhold both income and Social Security taxes for the other M.D.

On the other hand, suppose one doctor calls on another to fill in during a vacation and pays him a fixed percentage of the fees received from patients. Here, the assisting physician is *not* an employe, since he is solely responsible for his own actions and may even use his own equipment.

Some cases are particularly tricky. One physician had a cleaning woman who came in for an hour a day, five times a week. He had not been withholding taxes for her, on the theory that she was an independent contract laborer. But a Bureau of Internal Revenue agent insisted that the woman was an employe and should have been on the payroll. His argument: The doctor furnished the equipment and specified the job to be done; indeed, the M.D. fitted practically all the accepted criteria for an employer. The case is now before the bureau's legal staff for a ruling.

Paradoxically, if a doctor employs his father, mother, wife, or child under 21, he must skip the Social Security withholding—even when the employer-employe relationship fits all the criteria. (Apparently, Congress feared that professional men would go through the motion of hiring parents, wives, or minor children, just to obtain for them the benefits of Social Security.) Remember, though, that the physician must still withhold *income taxes* for any such employes.

While the doctor whose wife acts as his secretary and who employs only domestic help has relatively few taxes to withhold, the average M.D. with such office help as secretaries and technicians finds no easy way out. He must withhold taxes in at least three different categories—income taxes, Social Security deductions, and unemployment insurance—and he must file a variety of reports at a variety of times.

Some months, the volume is fairly light; but when monthly, quarterly, and annual reports coincide, they can be a prime source of irrita-

"Why, the holes are for the pain to come through, of course."

tion. A physician may have to contend with all the following forms (available by number at any Internal Revenue Office):

Form W-4: Federal Withholding Certificate. This is filled out by the new employe but must be kept on file by the doctor and produced whenever the Government so requests. On it, the worker lists his name, address, Social Security number, and the number of his exemptions.

Form SS-5: Application for a Social Security Account Number. Technically, this is no concern of the doctor's. But an employe has to have a number in order to work. If he doesn't already have one, the doctor had better tell him about it.

Form SS-4: Employer's Application for an Identification Number. A physician with even one employe must register with local Social Security or Internal Revenue offices within a week after he starts to pay wages. He must list his type of business and the number of employes.

Form 941: Employer's Quarterly Federal Tax Return. By midnight of the last day in April, July, October, and January, every employing physician has to file this combined statement of total withheld income

Lament for a Sunday Afternoon

(From a hospital resident with a crystal ball)

● It is 4:30 on a Sunday afternoon at the City Hospital.

Somewhere in town, as I sit here trying to break in a 69-cent pipe I got from a mail-order house, a slightly tipsy middle-aged man has just picked an argument with his wife, who is not above crowning him with an ash tray.

Elsewhere, in a bar, a young man is loudly resenting another's casual slur, not knowing that the second fellow has a friend who is accurate with a brick.

Out in one of the red-plush residential districts, a mother is bemoaning the fact that she failed to notice Junior toddling too close to the head of the stairs. She is unaware that she can't get in touch with the most expensive surgeon in town, who happens to be slumming in Newport, R.I.; but she will be democratic enough to accept the services of a hospital resident as the flow of blue blood accelerates.

A young man on the other side of town, who has been vomiting for the last hour, has discovered that his stomach-ache has moved downward

taxes and Social Security contributions. Payment must accompany the form.

Form 450: Federal Depository Receipt. If a doctor's total tax and Social Security withholdings exceed $100 in any month, he must deposit the money at the Federal Reserve Bank for his district by the fifteenth of the following month—even though returns are due only quarterly. He fills out a Federal Depository Receipt and sends it in with his check. It comes back stamped and must be attached, as support of payment, to the next Form 941 filed.

Form W-2: Annual Withholding Statement. By midnight of January 31, the physician-employer must file a separate statement for each employe, showing the employe's total earnings and the amounts withheld for his income taxes and Social Security. The employe gets a copy, too, for use on March 15.

Form W-3: Annual Withholding Reconciliation Statement. In January, doctors must also file a form showing how quarterly withholdings (reported on 941's) add up to the annual totals shown on the individual W-2's.

Form 940: Federal Unemploy-

---

and to the right. (Meanwhile, the admitting officer, who usually sees diagnostic problems, is getting ready for a shower in the house staff quarters. He doesn't know that the catch-latch door to his room is about to be blown shut, imprisoning behind it his trousers and keys—indeed, everything he owns but the B.V.D.'s he's wearing.)

Not far west of the city, a 1936 Dodge is hurtling eastward at a speed incommensurate with its age. Its driver has had a slight nystagmus since birth. He vomits when he gets excited.

In a small rooming house downtown, an elderly man has sobered sufficiently from a three-day bender to remove his socks and to notice that the sore on his left little toe has got out of hand. This gentleman is a veteran of the Spanish-American War and knows his rights; he also knows that City Hospital is a lot closer than the old V.A. hospital. He is stone deaf.

In a small apartment about ten minutes' drive from the hospital, my wife is pressing a blouse in preparation for coming over to eat Sunday supper with me. She is happy at the idea. She hasn't seen me for three days, because I'm on accident-room duty. Fortunately, she will get here unscathed.

But—unfortunately—all the other people just described, except the admitting officer, will arrive here precisely at 6 P.M. END

By John L. Meyer, M.D.

ment Tax Return. As part of the Federal Unemployment Tax Act, employers *of eight or more individuals* must pay an annual 3 per cent tax on wages (up to $3,000 per employe), by January 31. Where state unemployment insurance systems are tied in with the Federal—as they are in most states—employers can deduct payments to the states plus merit-rating credits, if any, from their tax liability.

There's still another tax form that the physician-employer must contend with: his state's unemployment tax return. Almost all states demand this, though rates, deadlines, and other requirements vary.

There is no way to make substantial cuts in the work of withholding. Figuring amounts to be withheld can, of course, be avoided by the use of withholding tables prepared by the Bureau of Internal Revenue; and keeping track of the figures can be simplified by using forms especially designed for payroll records. But that's about the extent of it.

The thing you *can* do is to avoid making the chore any worse than it is. This means doing it systematically, without confusion, and sidestepping the pitfalls that can complicate the tax-collecting process if you happen to stumble into them. Here are some things to watch out for:

¶ Make sure you file on time; late filing—or failure to file at all—may subject you to as much as a 25 per cent penalty, plus interest.

¶ Treat bonuses and gifts as employe income—and withhold from them as you would from ordinary income. Value any non-monetary gifts in dollar terms and compute the withholding tax accordingly.

¶ Remember that only the first $3,600 of each employe's annual income is subject to Social Security withholding.

¶ Keep your records for at least four years, to avoid any argument with revenue agents over the accuracy of your returns. END

Cottontail

• An old farmer brought his pregnant, 20-year-old daughter in, for me to examine. They were obviously poor, but he swore he'd pay somehow for the delivery. Would I take his cow for my fee?

"Why not let her husband worry about that?" I asked.

"She ain't got one."

"Then make the man who's responsible pay the bill."

"Tain't possible," he said. "Findin' *him* would be like tellin' which briar stuck the rabbit in the briar patch."

—L. W. COPELAND, M.D.

Groups Are Booming in California

And they're setting up their own patterns of organization, salary, hospital affiliation

• The modern medical gold rush to California is a group rush. Nearly one doctor out of twelve there is practicing in a group. Group practice has absorbed more than twice as great a percentage of the doctors in California (8 per cent) as in the country at large (2 to 3 per cent). And its growth is accelerating.

In the first five years after World War II, nearly twice as many groups were formed as in a comparable period before the war.

These facts emerge from a survey of the state's medical groups, published this summer by U. of C.'s School of Public Health. The survey was prepared by Dr. E. Richard Weinerman and George S. Goldstein. It is based on fifty-two "true" medical groups (as distinguished from eight single-specialty groups, two part-time groups, and thirty less formally organized aggregations of physicians).

"Medical group practice in California tends to be predominantly an urban phenomenon," the survey observes. More than half the fifty-two groups, embracing nearly three-quarters of the 849 group physicians in the state, are practicing in two metropolitan areas—Los Angeles and San Francisco.

That form of group organization in which all physicians are legal partners no longer dominates the California scene. The survey indicates that groups of this kind are now outnumbered two to one by those in which the doctor-partners employ other doctors.

What other patterns, according to the survey, do California's groups tend to impose on doctors?

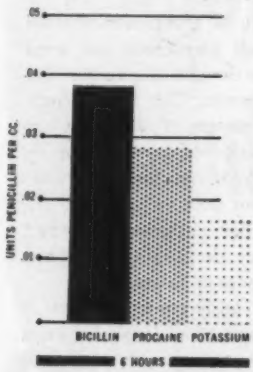
1. *They apparently practice in large groups.* California's groups have an average of twelve full-time physicians, as against eight for the country as a whole. Two of the California groups, the 23-year-old Ross-Loos Clinic and the war-born Permanente Foundation, include more than 100 doctors each. The Palo Alto Clinic is composed of fifty-one physicians; the Santa Barbara and the Moore-White clinics have nineteen men each.

2. *Prepayment plans supply much of their income.* More than half the group doctors in the state are with the ten groups that operate

---

By Helen C. Milius

the ***new*** *penicillin compound*



Average penicillin blood concentrations following oral liquid doses of Bicillin, potassium G and procaine penicillin. Single dose of 300,000 units. 30 adult subjects in 3 groups of 10. Each group received a different penicillin on each of 3 succeeding days.

effective

produces higher blood levels at 6 hours than similar fluid oral procaine or potassium penicillin preparations in equivalent doses.

palatable

no penicillin taste or aftertaste. Children and adults willingly adhere to dosage schedule.

stable

for at least 18 months at ordinary room temperature (77°F. .

ready to use

no tedious preparation.

1 teaspoonful (5 cc.), supplies 300,000 units (approximately 300 mg.). May easily be diluted for fractional dosage.

SUPPLIED: Bottles of 2 fl. oz.

oral suspension

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Benzethacil

N,N'-dibenzylethylenediamine dipenicillin G

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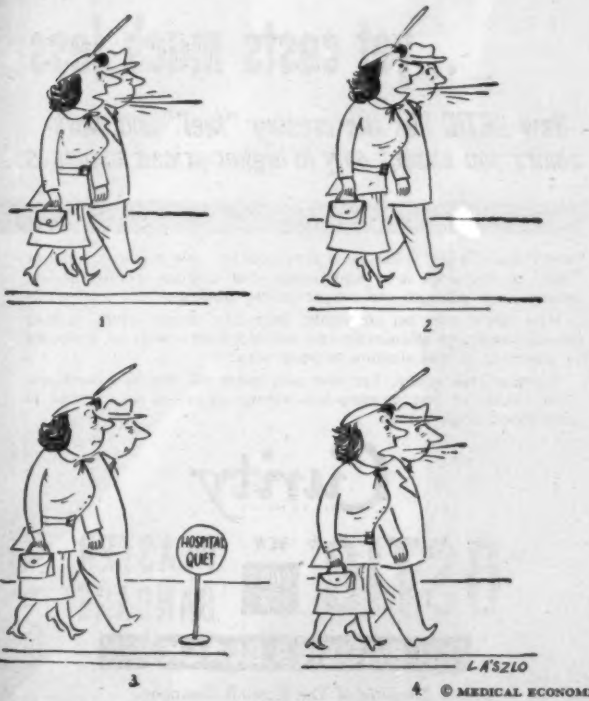
their own prepay plans. The survey finds these plans, in most cases, more comprehensive than Blue Shield; they cover services of physicians in the office and on home calls as well as in the hospital.

The Permanente and Ross-Loos plans loom largest on the prepay scene. Among the smaller groups following suit, the W. E. Branch Clinic of Hollywood offers a prepay plan for patients in lower-income brackets. The prepay plan of a San Diego group is consumer-sponsored.

3. *They get salaries instead of fees.* Some 84 per cent of the group medical men are paid salaries, the survey reveals. More than half are on straight salary. About one-fourth receive a percentage of net profit or some other form of bonus, in addition. Salaries in groups advance according to training, accreditation, experience, and specialty status, the survey finds, with additional credit in some groups for seniority or for volume of medical services rendered. A few groups make al-



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lowance for the number of patients the physician brings in.

A sample average-size group that offers its physicians an incentive reward guarantees its G.P.'s a base income of $700 a month, its specialists $1,000 a month. The incentive pay boosts their average to about $1,050 and $1,500 respectively. This represents net income, as the group pays all expenses, including costs of malpractice insurance and automobile maintenance.

4. *They tend to affiliate with hospitals in group units.* More than half the groups have unit hospital affiliation. Eight own their own hospitals. These include, in addition to the Permanente Foundation, the clinics in El Monte and Woodland, and the Harriman Jones Clinic in Long Beach. END

Will Abuses Choke Prepay Plans?

They may, if allowed to go unchecked, says doctor, citing flagrant examples

● Further increases in Blue Cross and Blue Shield premium rates, some fear, may discourage new subscribers and bring the plans' spectacular growth to a standstill. One such viewer-with-alarm is Dr. Elden C. Baumgarten of Detroit.

As he sees it, Blue Cross and Blue Shield have no alternative but to reduce costs in order to keep premium rates from rising still higher. And the best way to reduce costs, he recently told officers of the North Carolina medical society, is to cut down on patient and doctor abuses of the plans.

Dr. Baumgarten became convinced of this a little over a year ago, when he studied the situation at his local 185-bed hospital. Of twenty-six patients who had been in the hospital two weeks or longer, nineteen, he found, had Blue Cross coverage. Only three of the nineteen, in his opinion, still needed to be hospitalized; sixteen were ambulatory.

The sixteen included: three diabetics under control, "two of whom were there because they felt they had no better place to go"; two postoperative patients "getting dressings every other day"; an 80-year-old man "who was irrational and incontinent, and had been brought in because the family wanted to spend Christmas without having Grandpa around." [MORE→

The "most flagrant" case involved a patient who "had so-called rheumatoid arthritis and was being treated with cortisone." During his thirty-two days in the hospital, his physician had given him ten written leaves of absence. "One was to attend a banquet . . . and several were for entire week-ends at home. This case cost Blue Cross $733 and Blue Shield $106."

In addition to such instances of unnecessary hospitalization, the doctor uncovered other abuses. Some examples:

"Orders had been written for expensive antibiotics in large doses and multiple varieties, and never discontinued. Large numbers of unrelated laboratory tests were ordered, seemingly to make an impressive appearance on the chart . . . Fictitious admitting diagnoses were made to get the patient admitted for prolonged diagnostic workups."

Every Sixth Day

The discovery of such extravagance at his own hospital led Baumgarten to make a more detailed study at a larger institution. He and a committee reviewed 1,276 [illegible] admitted to the hospital during [illegible] month. Their conclusion: 1,700 [illegible] pital days—about one-sixth of [illegible] hospital's capacity—had been [illegible] used.

This total included 560 hos[illegible] days for diagnostic studies [illegible] could have been done in a doc[illegible] office or an outpatient clinic; [illegible] days for cases involving roe[illegible] therapy and physiotherapy [illegible] 167 days for unnecessarily [illegible] post-operative care; 155 days [illegible] needlessly prolonged medical t[illegible] ment; and 133 days for unne[illegible] sarily long pre-operative care.

The Doctor's Responsibi[illegible]

Though he regards both pa[illegible] and doctor as parties to such v[illegible] tions, Baumgarten holds the do[illegible] primarily responsible. After all, reasons, the participating phys[illegible] "knows, or should know, the r[illegible] He is in the same position as [illegible] attorney-at-law. He is an office[illegible] the court and sworn to adhere [illegible] and observe the laws regardle[illegible] his sympathies toward his cl[illegible]

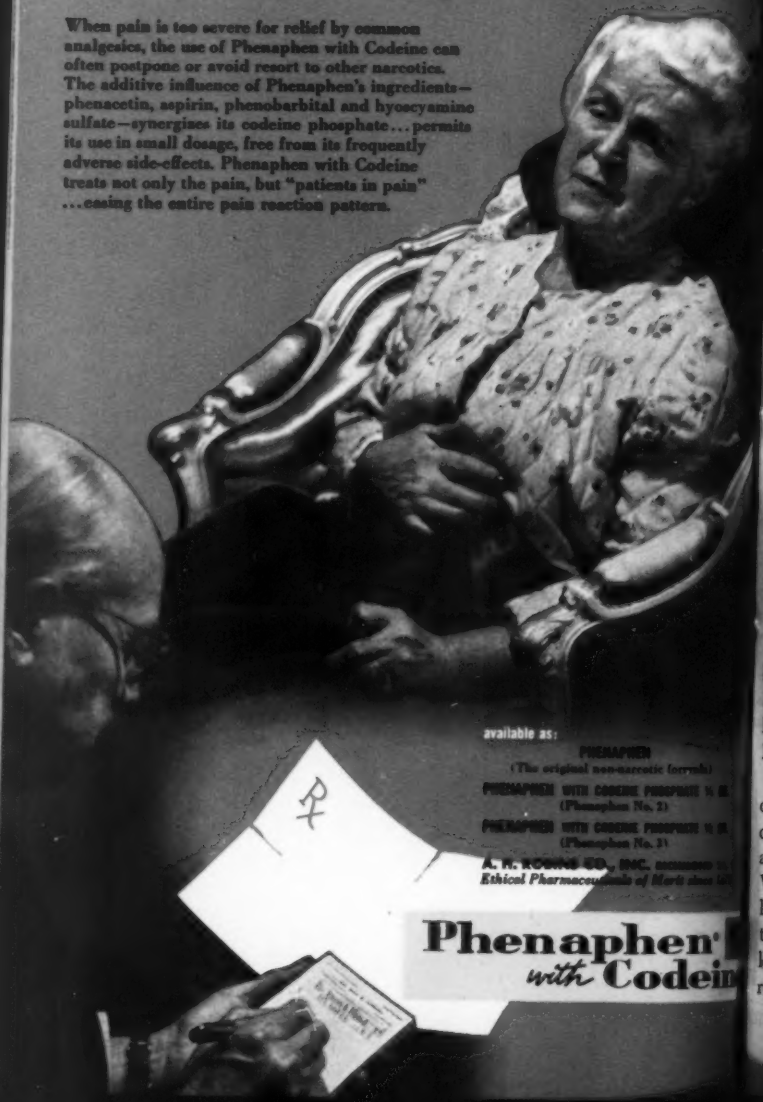
Memo to My Doctor

When you put the thermometer into my mouth,
Don't fancy I'm being immoral
If I think of the previous patient you saw . . .
Was the reading an anal, or oral?

—D. I. SPENCE

for **full** *codeine analgesia*
on **small** *codeine dosage . . .*

When pain is too severe for relief by common analgesics, the use of Phenaphen with Codeine can often postpone or avoid resort to other narcotics. The additive influence of Phenaphen's ingredients—phenacetin, aspirin, phenobarbital and hyoscyamine sulfate—synergises its codeine phosphate . . . permits its use in small dosage, free from its frequently adverse side-effects. Phenaphen with Codeine treats not only the pain, but "patients in pain" . . . easing the entire pain reaction pattern.



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PHENAPHEN WITH CODEINE PHOSPHATE ¼ gr.
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XUM

When Is a Doctor Bill Outlawed?

How to figure legal time limits on the collectibility of your accounts

As most doctors are aware, there is a time limit beyond which debts are no longer collectible. Not so well known, I've found, are the answers to these two questions: "*When* does a doctor bill legally become due?" and "*How long* does the statute of limitations run in my state?"

Take the actual experience of a physician I'll call Edgar Nunan. Dr. Nunan, an Ohio G.P., had been treating a patient off and on since 1935, most recently in 1945. In combing his accounts not long ago, the doctor noticed that the patient –let's call him Johnson–still owed him $121–the total amount of the bill. It wasn't that the man was a pauper; he just didn't want to pay up. So Nunan turned it over to his lawyer.

It was too late. Because the physician had been overly generous (and careless), his lawyer couldn't win a collection action against Johnson. Why? Because the Ohio statute of limitations says that a debt more than six years old is no longer collectible unless legal action has already been taken.

Every state, of course, has a similar law. As the table on page 131 shows, the time limit varies from state to state; but the top limit for collecting debts is, with one exception, six years. The exception: eight years in Wyoming.

Note that in many states the limit is less than six years. In Texas, for instance, a debt becomes invalid after two years. In fourteen states, the limit is only three years.

Now how do you determine the start of the period in which a doctor bill is collectible? Legally, this period begins when a specific illness is cured or when treatment is terminated. To figure the age of a debt, if no payment has been made on it, you simply count the years from then on. But if the bill has been partially paid, the statute of limitations generally runs from the date of last payment.

Consider, for example, Dr. Nunan's long-standing account with Johnson. The doctor had treated him first in 1935 for pneumonia, then three years later for a fractured leg, and finally in 1945 for pyelitis. Thus the bill for each illness was

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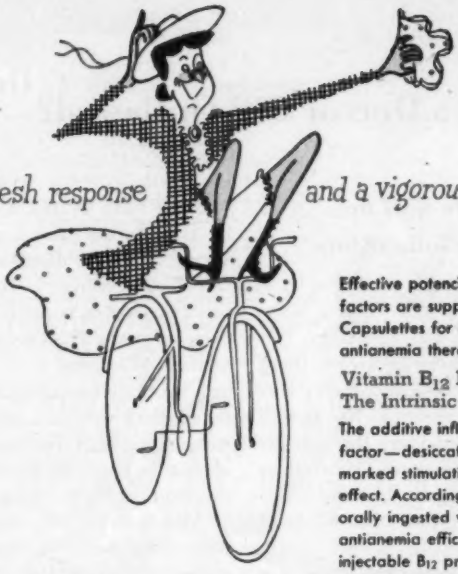
By Francis George, LL.B.*

**The author is a practicing attorney in Massachusetts.*



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350 mg.	Liver Fraction II with Desiccated Duodenum	350 mg.
1 mg.	Folic Acid	1 mg.
50 mg.	Ascorbic Acid (C)	50 mg.

*The Armour Laboratories Brand of Crystalline B_{12}

Effective potencies of all hemopoietic factors are supplied in Armatinic Capsulettes for comprehensive antianemia therapy.

Vitamin B_{12} PLUS Activated The Intrinsic Factor

The additive influence of the intrinsic factor—desiccated duodenum—has marked stimulating hemopoetic effect. According to recent research, orally ingested vitamin B_{12} has an antianemia efficacy similar to that of injectable B_{12} preparations when activated and potentiated by desiccated duodenum.[1-4] Moreover, folic acid has been shown to be one of the most active vitamin B_{12} potentiators.[5-9]

Armatinic Activated may be used in either the macrocytic or microcytic anemias (except in the initial treatment of pernicious anemia), whereas Armatinic Special fulfills a unique requirement for the macrocytic anemia patient in supplying the most potent activated hemopoetic factors *without iron*.

References: (1) Hall, B. E.: Brit. Med. J. 2: 585-589, 1950; (2) Bethell, F. H.: Univ. Hosp. Bull., Ann Arbor 15: 49, 1949; (3) Bethell, F. H., et al.: Ann. Int. Med. 35: 518-528, 1951; (4) Spies, T. D.: J.A.M.A. 145: 66-71, 1951; (5) May, C. D.: Am. J. Dis. Child. 80: 2, 1950; (6) Lubley, A. L., and Wheeler, W. E.: Health Center J. (Ohio U. Univ.) 3: 1, 1949; (7) Reisner, E. H., and Weiner, L.: Bull. New York Acad. Med. 27: 391, 1951; (8) Griffenhagen, G. B., and De Gan, E. F.: J. Am. Pharm. Assn., Sc. Ed. 41: 181-184, 1952; (9) Diez, Rios, F., Morales, F. H., and Meyer, L. M.: Ann. Int. Med. 36: 1076, 1952.

computed separately, and each debt became outlawed six years later.

If the pyelitis treatment had been completed five years ago instead of seven, Nunan could still have collected for it (but not for the other work). Unfortunately, all three bills had run past their legal limit. So Johnson was under no obligation to pay.

Of course, when a physician treats a chronic disease, his services are often continuous or intermittent; at no time is treatment actually completed. So, technically, the limitation period never begins in such cases; and the periodic bills remain legally collectible, regardless of the statute of limitations.

Other exceptions may also work to the doctor's advantage. In most states, for example, if a debtor makes a part payment *after* the statute of limitations has expired, he revives the debt for another full statutory period. The statute has then been waived and the doctor can sue for the balance.

The doctor's legal claim on a debt may be similarly revived if, after the end of the original statutory period, the debtor gives him a written promise to pay.

But for the most part, if you delay too long, you may find yourself in Dr. Nunan's predicament: You will have lost the legal right to collect.

END

The Legal Limits of Debts

Following is the term of years in each state during which there is legal obligation to pay debts. If legal action is not taken to collect a bill within this period, the debt is outlawed—and a doctor, for example, cannot sue his patient to recover.

2 years: Texas

3 years: Alabama, Arizona, Arkansas, Delaware, District of Columbia, Florida, Kansas, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, Virginia, Washington

4 years: California, Georgia, Idaho, Nebraska, Nevada, New Mexico, Utah.

5 years: Illinois, Iowa, Kentucky, Missouri, Montana, West Virginia

6 years: Colorado, Connecticut, Indiana, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Vermont, Wisconsin

8 years: Wyoming

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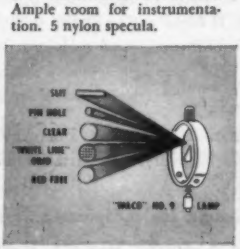
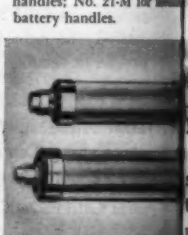


Rotatable unit in No. 110 ophthalmoscope gives standard, pinhole or slit apertures, white line grid and red-free filter. No. 106 ophthalmoscope, without rotatable unit, at lower cost.



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How You Look to the D.P. Doctor

Are American medical men inclined to be too cocksure and too impersonal? 'Yes, but they're competent too,' say foreign-born colleagues

• "By contemporary European standards American doctors are good—very good. But they'd be even better if they weren't so dazzled by their own brilliance."

This remark, voiced by a Rumanian surgeon now practicing in Brooklyn, is typical of what several D.P. doctors told me during a lengthy series of interviews recently. It seems a fair measure of the way U.S. doctors are regarded by European colleagues who have come to America since the end of World War II.

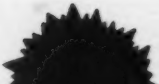
The doctors I interviewed represent a wide range of European nationalities. They lived formerly in places as far apart geographically as Latvia and Israel, and as far apart politically as Great Britain and Soviet Russia. Some of them were in practice before Hitler came to power. Others sifted their education out of the post-war rubble.

These men are understandably reluctant to criticize anything American. They remember only too well their agonizing experiences back in the homeland. They realize their good fortune in reaching this country while so many others have failed in the attempt. Invariably, they are a bit overwhelmed by the expensive splendor of American medicine. So it takes some prodding before they'll admit that American M.D.'s have *any* faults. But in candid moments they come up with some observations that merit reflection.

Like most European M.D.'s who have emigrated to America since the war, the doctors I talked with have settled in and around New York City. For this reason, it's debatable whether they're qualified to pass judgment on their American colleagues in general. Nevertheless, their remarks would seem to give at least the metropolitan U.S. doctor a chance to see himself as outsiders see him.

Many D.P.'s maintain, for example, that the American doctor doesn't command the patient-confidence that his European counterpart does. Says a former Prague specialist: "Here the doctor is considered on a par with the lawyer and the busi-

By Otto F. Reiss



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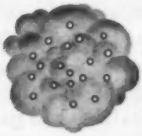

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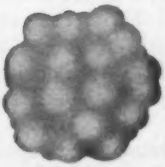

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nessman. In Czechoslovakia, his standing is more like a priest's. Perhaps that's why at home I never heard of such a thing as a malpractice suit."

Why are American patients so irreverent? One reason, the Prague man believes, is that they absorb too much pseudo-scientific information from lay medical writers. After digesting a few of the latest articles, they're inclined to think they know more about medicine than their doctor does.

Personal Touch Lost

Several of the displaced doctors I talked with feel that U.S. physicians tend to treat patients as "cases" rather than as human beings. "In my country," remarks a Balkan immigrant, "we always inquired at length about the patient's family and business affairs. We felt we were putting him at ease and thus establishing a solid doctor-patient relationship. Here, doctors feel that everything must be strictly business. The result is that they treat the disease—not the patient."

Adds another ex-European: "Nothing, to my mind, can ever take the place of careful bedside diagnosis. Yet that has become something of a lost art here. American doctors rely too much on laboratory tests, and they're often as gullible about the latest wonder drugs as

"Yes, Mr. Dee's fever has gone. And so, by the way, has Mr. Dee."

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With the recent introduction of Solution Intramuscular Veriloid, it is now possible to depress the blood pressure for prolonged periods by intramuscularly administered medication. Thus, in the management of the hypertensive patient, when it is imperative that the distressing symptoms be promptly controlled or mitigated, Solution Intramuscular Veriloid makes possible this therapeutic aim.

DESCRIPTION

Solution Intramuscular Veriloid provides 1.0 mg. of alkavervir per cubic centimeter in buffered isotonic aqueous solution. Alkavervir, an extract of hypotensive alkaloids derived from Veratrum viride, is biologically standardized in dogs for uniformity of hypotensive potency.

ACTION

A single injection of Solution Intramuscular Veriloid produces a significant drop in blood pressure which reaches its maximum effect in 60 to 90 minutes. The hypotensive response so achieved is maintained for 3 to 6 hours, at which time the initial dose may be repeated for a more prolonged effect. This procedure may be repeated several times if it is desirable to maintain blood pressure depression for a period of many hours, or even days. Solution Intramuscular Veriloid drops the blood pressure physiologically by central action. It has no influence on ganglionic activity and has no direct relaxing effect on the blood vessels.

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Solution Intramuscular Veriloid may be employed to maintain the hypotensive response of previously administered intravenous veratrum extracts, or it may be employed as the initial hypotensive agent. In either manner of use, it produces a positive hypotensive response in *hypertensive states accompanying cerebral vascular disease, malignant hypertension, hypertensive crises (encephalopathy), toxemia of pregnancy, eclampsia and pre-eclampsia.*

DOSAGE

The dosage of Solution Intramuscular Veriloid must be carefully ascertained for the individual patient. Complete information regarding dosage and administration is contained in the leaflet which accompanies each ampule.

AVAILABILITY: Solution Intramuscular Veriloid is supplied in 2 cc. ampules in boxes of 6.

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laymen are. I realize that they've made great strides recently; but I wonder if the end result won't be to change them into glorified technicians."

Eye on the Dollar

A Hungarian-trained M.D. carries his criticism a step further: "Some American physicians obviously place economic considerations above the patient's welfare," he charges. "For example, there seems to be a conspiracy among doctors and pharmacists to keep patients from knowing what's in a prescription. In Hungary it was usual to give the patient a copy of the Rx. Then, if he changed doctors, the new physician could easily determine what therapy had been used before. Over here, the pharmacist doesn't even copy the prescription on the label. I suppose this mystery helps a doctor keep his patients; yet I doubt that it serves the best interests of the patient."

This Hungarian doctor also criticizes the tendency of American M.D.'s to condone overcharges by druggists: "Why should the same prescription cost $7.80 in one pharmacy and $12 in another? Obviously, it shouldn't. Yet I hear reports of that sort of thing every day. I do my best to get after druggists who overcharge. But it's a lonesome, thankless job—especially for a newcomer like myself."

While deploring some American doctors' overemphasis on money, many D.P.'s admit the wisdom of introducing sound business methods into the practice of medicine. For one thing, they point out, the average U.S. patient has apparently been educated to pay his bills promptly. He is, in fact, "a model debtor," says one newly arrived practitioner, admiringly.

In Europe, he points out, it's customary to pay doctor bills either at the end of the year or, at best, when the treatment is completed. "Over here," he marvels, "it's not unusual for a patient to want to settle up after every visit."

To foreign-trained medical men, American patients also seem remarkably willing to submit to operations. "In Europe," says a displaced gynecologist, "I used to dread telling a woman she needed an operation. Now I have a hard time convincing some patients they *don't need* surgery."

One ex-European credits the lay press and voluntary health agencies with helping to ease the public's fear of surgery. But more important, he points out, is the progress made in the development of operative techniques in this country in recent years.

Most D.P.'s agree that medicine is now far more advanced in the U.S. than in Europe. And they don't pretend that this progress results solely from our economic advantages.

A Rumanian D.P. who, after teaching at the University of Paris, is now interning in a U.S. university hospital, says, "Medical students in

The "acceptability factor"
helps assure

fewer unfinished bottles

fewer rejected feedings

As significant as weight and growth gains are, the "infant himself is not at all interested." Of greater moment to him is "a feeding mixture he readily accepts."

clinical acceptability with SIMILAC

In a study considering the "acceptability" of various formulas, Similac was found to be "more readily accepted"—and very young prematures on Similac enjoyed a daily weight gain which was above average, and "regained their birthweight more readily than did the infants fed the other milk mixtures."

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folic acid and vitamin B_{12} (same amounts as in breast milk)
favorable calcium-phosphorous ratio

Similac is available in Powder, 1 lb. tins, and Liquid, 13 fl. oz. tins.

1. Bruce, J. W., Hackett, L.J. and Bickel, J. E.: Feeding Premature Infants, J. Pediat. *35*:201 (Aug.) 1949.

A QUARTER-CENTURY OF PROGRESS IN INFANT NUTRITION — M R

M & R LABORATORIES
Columbus 16, Ohio

the United States work twice as hard as those in Europe. They have to. In Europe, we had verbal exams and the professor often helped the student along. That can't happen in the written tests that predominate here."

On the other hand, says another D.P., American medical training, like American medical practice, lacks the personal touch. Whereas "some European teachers are famous for their dramatic lectures, professors over here strive for a sober, emotionless delivery." The result, he feels, is that there are few great American teachers and that American training suffers accordingly.

Our cold, businesslike methods are particularly in evidence in the training of internes, say several former Europeans. Adds one ex-German, who is now interning in a New Jersey hospital: "I'm so saddled with routine work that I don't feel I'm learning anything. It's been my experience that hospitals tend to use internes as low-cost labor without providing adequate training facilities in return. In Europe, where the interne is usually an unpaid student, he can devote all his time to useful study."

Favor Sick Benefits

How do foreign doctors stand on the issue of government in medicine? Without exception, the ones I interviewed are opposed to any full-blown welfare-state scheme like Britain's National Health Service; a few reminded me that they had come to America mainly to get away from forms of compulsion.

Nevertheless, most of them favor making certain sick benefits a part of our Social Security program. These doctors point out that a number of European countries have government-sponsored, semi-compulsory sick funds financed by salary levies. They claim that these funds work to the doctor's advantage, because they provide at least partial payment for the treatment of low-income patients.

Helping Hand Extended

But except for such tentative suggestions as this one, the doctors I interviewed seemed to find little need for improvement in the overall medical set-up here. The majority are particularly pleased with the welcome they've received from American doctors.

A middle-aged physician from Central Europe, for example, tells of making the rounds of doctors in the neighborhood where he wanted to set up practice. Only one advised him against settling there—and, ironically, that doctor was himself foreign-born.

Another D.P. invited neighboring physicians to refer night and weekend calls to him. Enough responded so that he was able to build up a busy practice. Two other D.P.'s report having been taken on as assistants by established doctors until they were ready to open offices of their own.

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But it's not all peaches and cream. Most of the newcomers find it extremely hard, for example, to gain hospital staff privileges. "They claim they have too many doctors already," is a common complaint. "Somehow," says a onetime Austrian surgeon, "my letters of application keep slipping to the bottom of the pile."

All things considered, though, the displaced doctors are warmly grateful for the chance to start practicing medicine again in the relative security that America offers. As one young Estonian M.D., who completed his medical studies in Germany in 1949, points out: "There are thousands of men like me still over there. Few of them can be sure of *ever* setting up a real practice like mine here." END

Quick-Starting M.D. When folks around Crooksville, Ohio, hear the roar of a motorcycle, they figure it's probably Almus Lawrence off on a race with the stork. An "enthusiast" (as ardent motorcyclists call themselves) for two years, Dr. Lawrence uses his high-powered Harley-Davidson regularly for house calls and for trips to hospitals in nearby Zanesville. "Saves me a lot of time," he says, "because I can weave through thick traffic and skirt around the jams." On professional trips, Motorcyclist Lawrence has a constant companion: his black physician's bag, strapped securely to the rear fender.

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To meet the varying needs of edematous patients, progressive therapy usually dictates a judicious blending of diuretics for optimal long-term re *Calpurate* lends itself admirably to such a regimen. It is the chemical compound—theobromine calcium gluconate—distinguished for its moder diuretic action and minimal toxicity. It is remarka free from gastro-intestinal and other side-effects, and does not contain the sodium ion.

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Letters to a Doctor's Secretary

How to keep the books so that daily, monthly, and annual totals all make sense

By Anna Davis Hunt

Dear Mary:

I want to start this letter by telling of an incident that took place several years ago.

One afternoon, the widow of a physician who had died suddenly came to see Dr. Barrie. Although she was past middle age, she had always seemed youthful and pretty. But on this occasion, I was shocked by her appearance.

I ushered her into Dr. Barrie's office, where she remained for a long time. Finally he rang for me.

Imagine my surprise when he said: "Miss Chase, do you know of any doctor who needs a receptionist? Mrs. Miller feels she would be happier if she had some work to do."

That was his tactful way of putting it.

I later talked with the woman and learned that after her husband's estate had been settled, not a penny remained for her support. He had even borrowed on his life insurance.

"Oh, Miss Chase," she said, tearfully, "he was such a good man, so kind to everyone. He always gave me so much. I can't understand where his money could have gone.

"You know," she went on, "he was *too* kind. He didn't have any money sense—*and neither did his secretary.* She had been with him for years and was fine with patients. But, oh, the books! You can't tell who's paid, or when, or where the money has gone. And he worked so hard . . . "

The next time I did my bookkeeping, I went at it with a sense of satisfaction I had never felt before. Why? Because I knew that if anything happened to me or Dr. Barrie at any time, an auditor could put his finger immediately on every detail of income or expenditure for the years since our present bookkeeping system had been inaugurated.

I shudder now to think of the in-

**These letters were published originally as a series in* MEDICAL ECONOMICS, *signed with the nom de plume Myrna Chase. In response to many requests, they are now being reprinted in revised and updated form. The complete current series, of which the present letter is the eleventh, will be made available in a portfolio.*

efficient manner in which our records were once kept. We had a little daybook in which we scrawled appointments and put down charges, hit or miss. These charges were later posted on the patients' ledger cards. In a larger book I listed the checks written each month and the payments collected. These payments were also posted on the patients' cards. But that was all!

New System Begun

I shall always be grateful to one of Dr. Barrie's business friends, who once happened to ask him about his bookkeeping methods. In a burst of friendly alarm over the doctor's revelations, the business man sent one of his auditors to look over our situation.

It was that auditor who set up our present system. I labored for hours to do his bidding, inwardly yearning for the old, simple ways. But when I got into the swing of the new program, it proved to be easy—and thoroughly enjoyable. It is profoundly gratifying to know there can be no leaks in charges and no mistakes in figuring and posting.

As the auditor told me, any good bookkeeping system should provide a ready method of determining the following:

1. Amount owed by each patient;
2. Total monthly practice volume;
3. Total monthly income, classified as to (a) cash at the time of service and (b) payments on account;
4. Collection ratio (the percentage of total receipts as against the total practice volume); and
5. Total amount and distribution of professional expenses.

This information, you'll find, is all at hand in the system, you now use. That system includes two elements: (1) a daily record book; and (2) the patients' ledger cards.

The type of record book, or log, we chose is easy to understand and was designed for use in a doctor's office. It is a loose-leaf book in which appointments, income, and expenses are recorded chronologically. Pages are provided for daily entries, monthly summaries, and a year-end summary.

Day by Day

Grouped by months, the daily pages in the log provide space for recording appointments and financial transactions. The columns are headed "Hour," "Name of Patient," "Services Rendered," "Charge," "Cash," and "Rec'd on Account."

In the appropriate columns, you enter the names of patients who have appointments and the times at which they are due. Operations and home visits are also recorded. Then, before office hours begin, you place on Dr. Barrie's desk a typewritten list of the day's appointments, just as they appear in the book.

As the patients arrive, you check them off in the book, and the doctor crosses them off his list as he sees them. If someone is admitted without an appointment, you and Dr.

Barrie both add the name and hour to your records, thus providing a check so that no charge is overlooked. Dr. Barrie's list also enables him to keep track of the time allotted to each patient.

After each office call is over, scan the patient's case history to see what was done for him. Then put a brief description, such as "Exam," "Boil incised," or simply "O.C." (for office call), in the column headed "Services Rendered."

What's the Bill?

The "Charge" column indicates the amount of each fee, regardless of how it is to be paid. At the close of every day, the doctor himself records these fees in the log. The amount of the charge, or a symbol explaining why a charge has not been made, is entered after every name. The symbols we use are as follows: "N.C." (no charge); "C" (canceled); and "F" (failed to keep appointment).

Dr. Barrie never leaves the office (barring a matter of life or death) without filling out the "Charge" column. There is an excellent reason for this: It is obviously easier to remember what was done for a patient, and to make a fair charge accordingly, on the day of his appointment.

Many a loss is prevented in this way. What's more, when the fee for an operation and the method of payment have been talked over, or when a reduction has been promised, the details of the conversation will not be forgotten if they are entered on the same day.

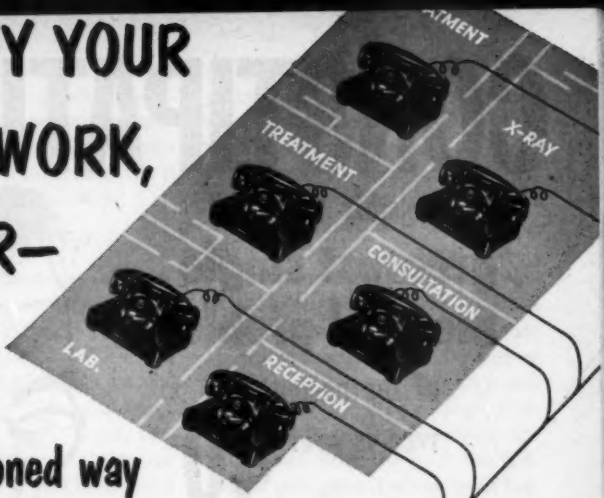
The last two columns of the daily page are headed "Cash" and "Rec'd on Account." If the patient's payment covers the immediate case, enter the amount in the "Cash" column. If he pays something on account, enter it in the "Rec'd on Account" column. In either event, follow your entry by a small "c" if you were paid in cash. Absence of the "c" indicates that payment was by check or money order.

You will usually have space left at the bottom of the "Appointments" column, where you can enter names and amounts of payments sent by mail; if you haven't, you can always insert an undated supplementary page to follow. (Some bookkeeping systems provide on the daily page a separate section marked "Bills Collected," where you can enter such payments.)

I recommend that you make daily bank deposits if any amount, large or small, has been collected. When you fill out the deposit slip, keep a carbon copy for your records, you must of course enter the same amount of currency as is shown on the daily page of the log; and the checks and money orders should be listed in the same order as on the daily page.

Your daily record sheet also provides space for listing disbursements. They're classified under such headings as "Personal," "Laundry," "Taxes," and "Salaries." (Some systems omit this daily record of

SIMPLIFY YOUR PAPER WORK, DOCTOR—



in the new fashioned way —and enjoy better medical records!

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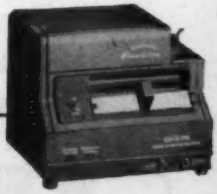
TELEVOICE saves you time —enough time to see two to five additional patients per day!



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*Rehfuss, M. E.: Indigestion, Philadelphia, W. B. Saunders Co., 1943, p. 322

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bursements, providing only monthly expense sheets.) As you pay each bill, indicate on it the date of payment and check number, and file it away with the other invoices.

The Monthly Total

The monthly summary of business is essentially an accumulation of totals carried forward from the daily pages. The left-hand column is numbered for the days of the month; then come "Total Charges," "Total Income," and "Total Disbursements." Here again there may be a breakdown of disbursements; this is valuable in computing income tax, as some items are deductible, others not.

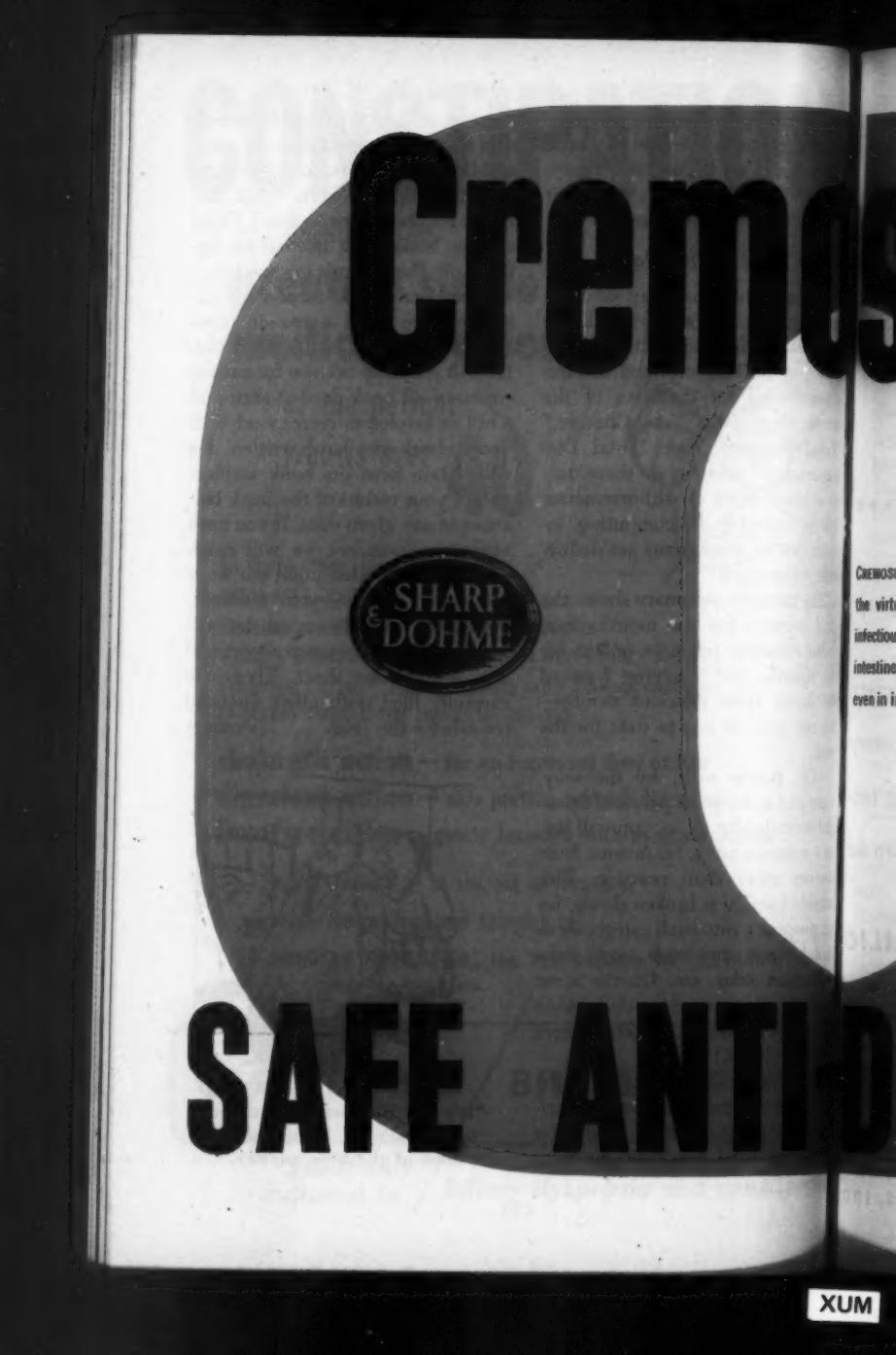
The monthly summary shows the total income for the month; total disbursements; net gain or loss for the month; and—carrying forward the figure from previous months—the net gain or loss to date for the year.

(Dr. Barrie may, by the way, want you to keep his personal financial records also. If so, you will list, on a separate page, his income from sources other than practice. This outside income is broken down, for tax purposes, into such categories as rent, interest, dividends, profit from real-estate sales, etc. On the same page you also record tax-deductible items—for example, capital losses and bad debts.)

The "Annual Summary" at the end of the logbook shows the various tax deductible items and their totals, the total year's income from practice, and total income from outside sources. Depreciation on automobile, instruments, and furniture is also computed here. (Ask Dr. Barrie for the figures on this.) These are the basic items needed for figuring out the doctor's income tax.

A certified public accountant visits the office twice a year—in January and July—and audits the books. He will probably ask you for carbon copies of all bank-deposit slips and a bill or invoice to correspond with every check you have written. He will obtain from the bank verification of your record of the bank balances at any given date. If you have made any mistakes, he will catch them and will often point out ways for you to improve your methods. When the audit is ended, he will send Dr. Barrie a written report and a typed balance sheet. These are carefully filed with other financial records for the year. [MORE→

"It's not his feet he's anxious to get back on. He sits around most of the time anyway."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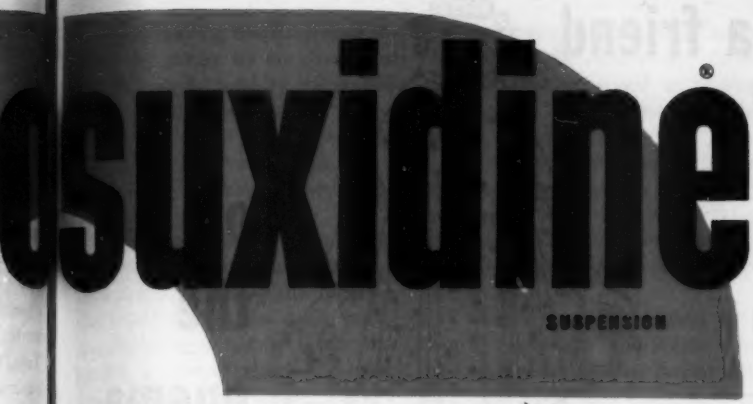

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Aside from the inconvenience, it provides only temporary relief and is actually irritating.

Here is where Turicum can be a big help in establishing normal function.

It is not a one-dose laxative but a treatment that, taken for a few days, helps restore normal function.

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Before leaving the subject of income and outgo, let me stress that all bills *must* be paid by check. The only exceptions are the tiny petty-cash items you list in a notebook in your desk. Dr. Barrie gives you a check for petty cash whenever you need it.

The doctor *never* appropriates for his own use any cash that may have come in during the day, for this would disrupt the whole bookkeeping system. Instead, he writes himself a weekly check for cash, which is recorded in the log. (In my next letter, I'll explain the correct care of the checkbook.)

Ledger Cards

An individual ledger card (common sizes: 5″ x 8″ and 4″ x 6″) is kept for every patient who is charged a fee. Each day, as surely as the sun rises, you must post on these cards the charges and payments recorded on the daily page for the preceding day, with a brief symbol indicating the service rendered.

Place a check-mark in the last column of the daily page to show you have posted that item on the ledger card. When a patient wants to make a payment, you are thus able to tell how much he still owes by glancing at his card.

You have no doubt noticed that one entire filing cabinet is given over to small drawers into which these cards fit. The top drawer is reserved for active accounts; the other drawers are used for paid-up accounts. The drawer containing the active accounts can easily be removed from the cabinet and placed on your desk, to speed up posting and getting out statements at the end of the month.

So now you have a full outline of the bookkeeping system I prefer. By making prompt, complete entries, routine is soon acquired; and the log and the ledger cards are no problem at all.

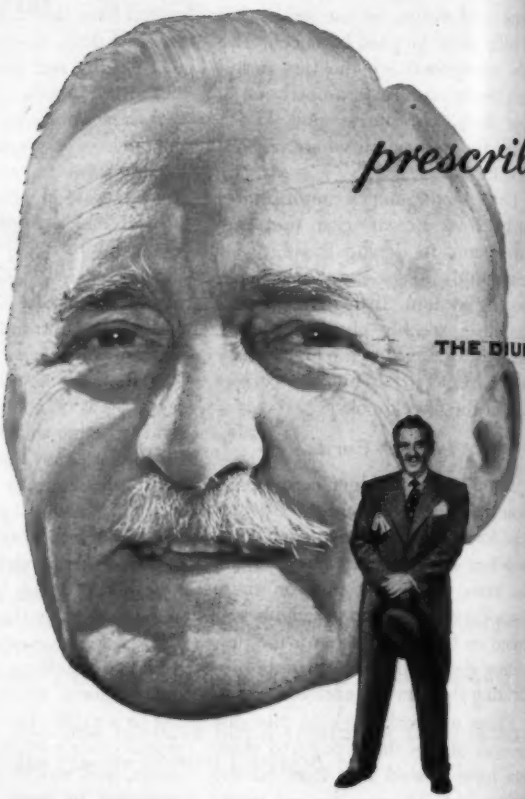
I once knew a physician who would never hire a secretary who had worked for another doctor. His first and most positive requirement was that she should have worked for a bank or a busy attorney. He paid a better salary than the bank or the attorney, and he saved it many times over in what she saved him. He always insisted that *he* could teach a secretary all she had to know about medicine, but that he couldn't teach her bookkeeping and business methods.

How I wish every doctor who has a likable, intelligent secretary without business training would send her to a night class in bookkeeping, would open a set of books similar to yours, and would pay the best accountant in town to audit those books twice a year! If, in addition to this, the young woman could work for at least a month in a first-class collection agency, she'd then really have something—and so would the doctor.

At any rate, I'm glad Dr. Barrie has you.

Affectionately yours,

Myrna Chase



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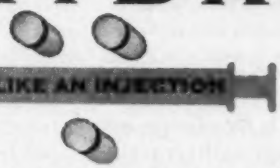

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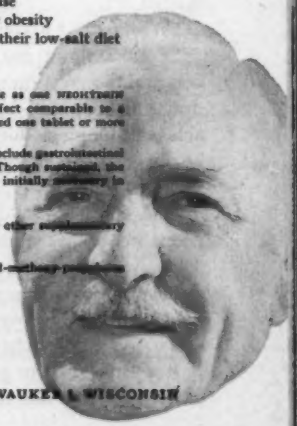

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Doctors' Wives Are a Problem

Not to the men they marry, perhaps—but have you ever tried treating one of them?

● When a doctor's wife comes to me for treatment, I'm certain of only one thing: I'm in for a hectic, exasperating, perhaps embarrassing, time. Take an experience I had recently:

This patient, as far as I could tell, had nothing physically wrong with her. But like so many other wives of busy doctors, she was in a highly nervous state.

"You really can't afford to get sick when your husband is a doctor," she started out.

"Why not?" I asked.

"For one thing, my husband is always on the go. When he thinks I'm dragging my feet, he gets angry—acts as though a doctor's wife has no business being sick. Or else he says I'm neurotic.

"If I complain loudly enough, he gives me a five-minute check-up. Then, when he can't find anything wrong, he ships me off to another doctor. I guess he wants somebody *else* to tell me I'm a hypochondriac."

It wasn't hard to get at the root of her problem. She finally unearthed it herself—even though, while I took her history, she artfully sidestepped all questions about her personal life.

"I'm just lonely," she said, at last. "I hardly ever see Fred nowadays. When I do, he's always dashing out the front door. If I cook one of his favorite dishes, he bolts it down so fast he can't possibly tell what he's eating. And when he's ready for bed at night, he's got just enough strength left to take his shoes off."

I knew that the medicine I recommended—a leisurely vacation trip with Fred—would have explosive side reactions. And it did. The next morning, Fred called me. He couldn't have sounded more upset if I had suggested going away with his wife myself.

"What's this nonsense you've been feeding Dora?" he wanted to know. "She's determined to take me off on a Caribbean cruise. How could you do such a thing to me, Bill? You know I can't leave my practice."

Finally he calmed down, bowed to the inevitable (his wife was determined to have her way this time) and closed his office for a month. When he and Dora came back from

By William Kaufman, M.

their trip, they looked better than they had in years.

Why did this case—unlike so many others involving physicians' wives—come to a successful conclusion? Mainly, I'm convinced, because Dora was sensible enough to follow the advice of the doctor her husband had referred her to. In that respect she differed from most colleagues' wives I've treated.

I suppose it's natural for the average doctor's wife to withhold complete trust from an attending physician. Through constant indoctrination, she has become skeptical of the value of any medicine or treatment. In the privacy of the bedroom, she has often heard her husband denounce certain members of his profession. Small wonder, then, that she finds it hard to develop faith in *any* doctor when she's sick.

One of the worst irritants is the colleague who sends his wife to me for treatment, then insists on overriding my advice. His interference seldom stems from a mature appraisal of the facts in the case. Generally, it's part of a rather juvenile desire to convince his wife that he knows more about medicine than the next fellow.

I suspect that's what made one colleague of mine so stubborn about his wife's headaches. She came to me against his better judgment. "My husband says there's no use wasting your time," she explained. "He says I'm the high-strung, migraine type—born that way."

After questioning her at some length, I got the idea that the headaches might be caused by—of all things—pineapple. She had told me she ate a lot of it, chiefly because her husband was so fond of it. So we made a clinical trial of the use and avoidance of pineapple. The results supported my guess.

Her husband, however, said it was nothing but coincidence. To prove the point, he dragged his wife to the nearest skin-tester. When her skin test was negative to pineapple, he gave a crow of triumph—and that ended the case.

But it failed to end the headaches. At last, when my pineapple-loving colleague lost interest in the game of shoving the fruit down his wife's throat, she decided to test my theory further. She stopped eating pineapple—and her headaches disappeared.

Rash Habit

One species of doctor's wife with whom I've had a good deal of trouble is the kind who believes in self-medication. Apparently she works on the theory that medical knowledge can be absorbed through the process of connubial intimacy with a physician.

One of these self-treatment addicts I remember well. Her husband, a urologist, wanted me to try to discover why her skin kept breaking out. My examination indicated that she had a drug rash—possibly from phenobarbital.

"What medicines are you taking?" I asked her.

[MORE→

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For a moment she looked puzzled. "Why, none," she said. "Not really." Then she smiled. "Of course, I do try the different samples that come in."

My mouth dropped open.

"Don't look so upset!" she said. "There must be *some* good in them for *somebody*; or the drug companies wouldn't send them out."

Few doctors' wives, I venture, are as naive as this one. Yet more trying to the attending physician is the wife who resents—and resists—his efforts to help her.

Resentment, I've found, is more common among physicians' wives than among almost any other class of patients. I can think of two reasons why this should be so: For one thing, the doctor's wife may take the entrance of another physician into her case as evidence that her husband doesn't want to be bothered by her troubles. For another, there's the possibility that she doesn't *want* to get well. I've known more than one wife of a busy M.D. who relied on her real or fancied ailments to force her husband to pay more attention to her.

Work Before Wife?

Only a few weeks ago, one of these "neglected" wives told me her troubles. "We just don't have a normal, relaxed family life," she said bitterly. "The whole world has first claim on Alex. We can rarely keep our social engagements, and I can't remember when we last had a few carefree hours together. Yet it would be unthinkable for me to ask him to change. His work comes first. It doesn't even do any good to ask him to slow down for his health's sake. He won't say no to any patient—only to me."

There wasn't much that I could do for her except hope that some day her husband would change his way of living. But I doubt if he ever will.

Private Investigator

Of course, it's not only wives of doctors with booming practices who create headaches for an attending physician. I've had a recurring problem lately with young women whose husbands, just out of training, want to know how medicine is practiced in our community. What easier way to find out, they reason, than for an observing (and invariably healthy) wife to become the patient of an established medical man?

For example, there was the young woman who had memorized a lot of facts about infectious mononucleosis. She recited her complaints to me as though she were a case history straight from one of her husband's textbooks.

Sprinkled throughout her recitation were leading questions about my practice. What would I charge a *real* patient for all the time she was getting? Did I always do blood counts on new patients? Was that extra? How did I vary my fee according to whether the patient was poor or wealthy? And so on.

Although I admired her zeal, I

would have preferred a less roundabout approach. So I told her that I hoped her husband would drop over for a talk with me sometime. I'd be willing to tell him whatever he wanted to know about my practice.

My remark must have rattled her for she left in haste; and when she'd gone, I discovered that she'd left in the dressing room a neat set of notes on her findings. I mailed them to her. But her husband has never taken me up on my invitation.

No Confidence

Actually, I'm sorry that this woman probably won't come back to me as a real patient. It isn't every day that a doctor's wife puts enough stock in the attending physician's words to take notes! Faith (that *sine qua non* of good patient-doctor relationships) is a rare commodity when the patient is a doctor's wife.

Often, in her anxiety not to displease her husband, a doctor's wife drops treatment prematurely. Or she may consult many physicians in rapid succession—if only to shop for an opinion acceptable to hubby. Sometimes, after giving up the struggle to get advice from others, she illogically elects to get along on whatever scraps of medical care her husband throws her way.

All of which leads me to conclude that the key to the problem is to be found not in the doctor's wife but in the doctor himself. If he tries to understand his wife's special emotional problems, he'll do his best to bolster her faith in the doctors she consults.

Once he has chosen the best doctors for her, let him continue his interest in her welfare—but *without* interference. Only then can he be confident that his wife will get the care she deserves. END

Yankee Clipper

• A New England medical credit bureau, after repeated attempts to collect a physician-client's bill for professional services, took the delinquent debtor to court. There the agency explained its case to the magistrate in some detail: The bill (for a child's circumcision) was certainly not out of line. What's more, the father was perfectly able to pay. So why didn't he?

The magistrate asked the father for *his* side of the story. He replied apologetically: "I don't like to be indelicate about this thing, Your Honor, but I question whether I rate a bill for the service mentioned. My only child—the one mentioned in this case—is a new baby girl."

—WILLIAM STEWART

Doctors Face Threat From Abroad

Treaty to be submitted to U.S. Senate calls for Government medicine

• "We are subject to attack not only from within the country but from without," Dr. Louis H. Bauer, A.M.A. president, recently warned the American medical profession.

The "attack from without," to which Dr. Bauer was referring, may come to a head during the next session of Congress, beginning January 3. The attack will be in the form of a treaty, submitted to the Senate. Ratification of the treaty could bind the United States to the development of a Government health insurance scheme.

The treaty was approved by the International Labor Organization last June, and it sets forth minimum social security standards for member nations. These standards, covering nine different fields, include medical care and the following benefits: sickness, unemployment, old age, employment injury, family, maternity, disability, and survivor.

The medical care section commits a nation to supply G.P. and specialist services, hospitalization, and drugs to about 50 per cent of the population. Lacking a compulsory system, a nation can provide such services through voluntary health insurance if it is *supervised by public authorities* or administered jointly by employers and workers according to standards *set by public authorities.*

To ratify the treaty, the Senate would have to approve by a two-thirds vote at least four sections, in which case the country would be obligated to fulfill only the sections approved. Thus, the treaty could be ratified without approval of the medical care section.

Actually, there's not much danger that the Senate will look with favor on any four sections, at least during its next session. But there's no time limit on ratification. Which means the President could submit the treaty for Senate approval any time he thought was ripe or any time it might offer political grist.

As a member of the I.L.O. (since 1934), the U.S. must report annually to that group what actions it has taken. Since the treaty sets up minimum standards of welfare, any nation not complying with those standards is open to slurs about its social backwardness. Thus the

By Roger Menges

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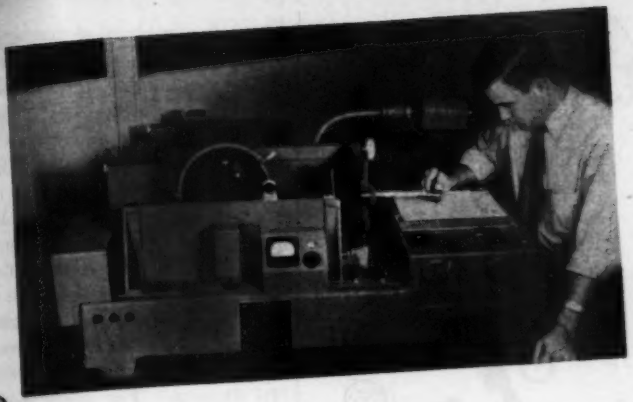

3. KODAK-MADE, this Automatic Recording Densitometer reads and records the densities of each test strip and experts interpret the resulting sensitometric curves.

Full-size sheets of Blue Brand Film undergo physical tests, x-ray exposure tests, microscopic study both of the surface and of vertical sections, plus an ordeal in the "Corridor of Climates" where the Blue Brand package must show it can endure a wide range of humidity.

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treaty has continuing propaganda value.

Many medical and industrial leaders are aware of the pressure such propaganda can create. Some, because of this, want the U.S. to pull out of the I.L.O.

They point out that the I.L.O., which was formed by labor groups in 1919 "to promote social justice in all countries of the world," has consistently plumped for socialization. Its very makeup, they contend, stacks the cards against capitalism. To illustrate: For every management delegate to the I.L.O., there are two government delegates and one labor delegate. Thus, labor and government, which usually vote together, have the controlling hand.

This bloc voting was apparent during the I.L.O.'s June meeting in Geneva. The vote of delegates from member nations, in favor of the social security treaty, was 109 to 22. Government and labor representatives lined up *for;* management representatives were mostly *against.* Even the U.S. delegation voted according to this pattern. (The U.S. delegation was appointed by President Truman.)

One American delegate who voted against the treaty was Charles P. McCormick, president of McCormick Tea & Spice Co. He said that even if he had favored the treaty in general, he would have voted against it because of the medical section. As it was, his opposition was overbalanced by the votes of the other three delegates: Senator James E. Murray (D. Mont.), chair-

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15 minutes before each oral dose of antibiotic

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1. Greenspan, R., MacLean, H., Milzer, A., and Necheles, H.: Am. J. Dig. Dis. 18:35, 1951. 2. Parsons, W. B., Jr., and Wellman, W. E.: Proc. Mayo Clinic 26:260, 1951. 3. Necheles, H., Kroll, H., Bralow, S. P., and Spellberg, M. A.: Am. J. Dig. Dis. 18:1, 1951.

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sponsor of the Wagner-Murray-Dingell bill; Assistant Secretary of Labor Philip M. Kaiser; and George P. Delaney of the A.F.L.

Doctors Bypassed

What irritated many doctors, both here and abroad, was the way the I.L.O. ignored their advice. Some months before the June conference, delegates received a report on the medical aspects of social security. This report was prepared at the request of the I.L.O. by a committee of the World Health Organization, which, as part of the United Nations, is the world counterpart of the U.S. Public Health Service. All members but one of this committee were physicians, but not a single member was a *practicing* physician.

Nor did the W.H.O. report reflect in any way the practicing physician's viewpoint. It recommended full-time, salaried medical service in every country because "the fee-for-service system exposes the physician to the temptation to care for a patient who should be sent to a specialist or an institution. It gives an incentive for the prolongation, rather than the reduction, of illness."

Neither the I.L.O. nor the W.H.O. had bothered to consult the World Medical Association, which represents practicing physicians in forty-three countries. So the W.M.A. decided to offer its advice, anyway.

"It says that under socialized medicine we won't have to pay no doctor bills. Hell, we don't pay none now."

Four officers, including Dr. Bauer, the secretary general, went to Geneva with a request that the I.L.O. also distribute to delegates a W.M.A. statement on social security.

This statement held that "a man should primarily be responsible for himself and his activities." When social security is necessary, it concluded, the aim should be to "raise the individual to a level at which he can help himself" and to "encourage self-reliance and a sense of personal responsibility."

Dr. Bauer and his colleagues were given a polite brush-off. The only person who could authorize the W.M.A. statement's distribution, they were told, was the chairman of the I.L.O. conference committee on social security—and he wouldn't be appointed until the convention got under way. The W.M.A. finally did get its statement into the hands of some delegates, but only by distributing copies through its liaison officer in Geneva.

Even before the I.L.O. approved


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its treaty, the A.M.A. had foreseen the likely results. At its Chicago session last June, the A.M.A. went on record against any treaty or executive agreement that "conflicts with any provision of the Constitution" or that "operates . . . to regulate any of the purely domestic affairs of the United States."

This same principle had been presented to Congress earlier, as Senate Joint Resolution 130, but no action had been taken. If eventually passed, it will block attempts, like the I.L.O.'s, to bore into the country's social structure from without.

But until such a measure becomes law, the I.L.O. treaty will hang over doctors' heads as a disturbing if not dangerous threat.

'Hitlers in Our Hospitals'

Anonymous author flays superintendents—and embarrasses a publisher

● What's at the root of the "strife and dissension in our hospitals"? An anonymous 38-page pamphlet now going the rounds of the profession charges that the real cause is "the determination of hospital superintendents to establish an absolute dictatorship in all phases of hospital management and operation."

Entitled "The Hospital Superintendent: What Makes Him Tick? A Study in Human Behavior," the pamphlet first attracted notice in June, when Chicago postal authorities held up a bulk mailing for insufficient postage. In violation of regulations, none of the pamphlets and none of the envelopes bore a return address. But on the pamphlet's last page was a lone clue to its source: "Additional copies of this book may be obtained from the Chicago Medical Book Company."

Confronted with this statement, the book company said it had never heard of the pamphlet and therefore had no copies to distribute. But since then, it has heard plenty. Its advertising manager, A. C. Bowers, says, "Apparently there's been a large number of these pamphlets circulated. We have had requests from the East, West, North, and South for additional copies."

The anonymous author himself throws no light on the mystery. In the concluding paragraphs of his text, he points out that his accusations were originally presented to a

By James C. Fuller

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county medical society (unnamed) whose members urged him to write and distribute the pamphlet. His views, he adds, are based (1) "on the literature of hospital superintendents" and (2) "on the observations and experiences of over 35 years."

The pamphlet begins with an ironic statement of the hospital superintendents' credo:

We are men of "great ability and competence." We are "pure in heart and have the highest motives." And those of us with M.D. degrees "have sacrificed a brilliant career in the practice of medicine to become hospital superintendents."

Not So, He Says

Then the pamphleteer squares off: Actually, such hospital superintendents are "men of small talent," he cries; for "no man will go through the mental and financial ordeal necessary to obtain an M.D. degree and then voluntarily surrender the much greater rewards" of private medical practice, unless he has failed in such practice.

By the time the average superintendent attains a position of authority in hospital management, says the pamphlet, he has become thoroughly embittered by his failure in medical practice. With his "tremendous economic power," he then proceeds to terrorize the members of the professional staff.

As an example of such browbeating, the pamphlet cites an article ("Medicine's Problem Child—the Hospital," MEDICAL ECONOMICS, August, 1951) whose author, in fear of reprisals, used a pseudonym. "Shades of Adolf Hitler!" says the pamphlet. "Is it possible that this small group of less than 1,000 misfits can terrorize the 150,000 fine, decent physicians of this nation into submission?"

The "divide and conquer" technique of the superintendents crops out particularly, it charges, in their "bitter opposition" to the appointment of doctors to governing boards. The reason given for such opposition: A board that included such "informed members . . . would prevent hospital superintendents from exploiting the ignorance of lay members" and from reducing trustees "to the role of . . . rubber stamps."

By taking advantage of the trustees' ignorance, says the pamphlet, the superintendent can also cheat the doctors. The process is simple: "By confiscating a goodly share of the income of the medical profes-

sion, the coffers of the hospital can be filled to overflowing . . . Then the hospital superintendent will be rated a genius by the trustees."

A protector-of-the-public pose is said to be assumed by almost all hospital superintendents in their cultivation of the lay public as well as of the hospital trustees. Generally, says the pamphleteer, the superintendents' attitude is that "We are paragons of virtue, while the medical profession is made up of incompetent, greedy men." To which he retorts:

"The idea that the failures and misfits of our profession are forming themselves into an elite corps that

Do You Know Your Medical Proverbs?

By Webb Garrison

• All through history, medical men have been a subject dear to the proverb makers. As a result, proverbs about doctors are a dime a dozen. Below are nine of them—slightly scrambled—with the names of the countries in which they originated.

Can you fit the proper halves together? After penciling in lines to connect each proverb's beginning with its correct ending, check your answers on page 182.

1. (English) A patient who makes his doctor his heir ..... *is better than a good one.*
2. (Spanish) The presence of the doctor ..... *is best when he is old.*
3. (Russian) A doctor's mistake.. *is not likely to recover.*
4. (German) A lucky physician.. *is medicine for the doctor.*
5. (Polish) The patient's gold .. *is the first part of the cure.*
6. (Roman) Every man at thirty. *is better than three.*
7. (English) A physician, like beer, ... *is the one you run for and can't find.*
8. (French) The best doctor ... *is the will of God.*
9. (Scotch) No doctor at all .... *is either a fool or a physician.*

will supervise and police the medical profession would be ludicrous if it were not so tragic."

The quoted examples by no means exhaust the "infiltration tactics and flanking movements" cited by the pamphlet. Among other alleged maneuvers of superintendents:

¶ "Their attempt to seize control of the standardization program";

¶ Their use of Blue Cross medical care provisions "to increase their intrusion into the practice of medicine";

¶ Their promotion of the hospital as a public health center "to further extend their sphere of authority";

¶ Their "capture" of such specialties as radiology, anesthesiology, and pathology.

Having found the superin... ents guilty on every count, the ... phlet's author makes three re... mendations for keeping th... bounds:

1. Let the hospital superin... ent revalue his function realisti... "With doctors doing the docto... the teaching, and the research, ... [with] nurses doing the nursing, ... major functions of the hospital ... being performed. The one role l... and it is a most important one, ... that of the coordinator . . . w... keeps the buildings, equipme... and personnel available."

2. Place more doctors on gover... ing boards. "Had the hosp... boards throughout the nation ... an adequate representation of ... tors chosen for their ability by ...

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staff, this usurpation of power by hospital superintendents would have ended long ago."

3. Doctors themselves must face up to the fact that by their "sins of commission and omission" they have "made possible the insidious program which I have outlined."

All this, however, fails to answer two basic questions:

Who wrote the pamphlet? And why did he allow *himself* to be frightened into anonymity?

Medical Proverbs

[SEE PAGE 179]

1. The patient who makes his doctor his heir is not likely to recover.

2. The presence of the doctor is the first part of the cure.

3. A doctor's mistake is the will of God.

4. A lucky physician is better than a good one.

5. The patient's gold is medicine for the doctor.

6. Every man at thirty is either a fool or a physician.

7. A physician, like beer, is best when he is old.

8. The best doctor is the one you run for and can't find.

9. No doctor at all is better than three.

[EDITOR'S NOTE: You needn't blush if you flunked this test. Most of these proverbs were Greek to us, too!]

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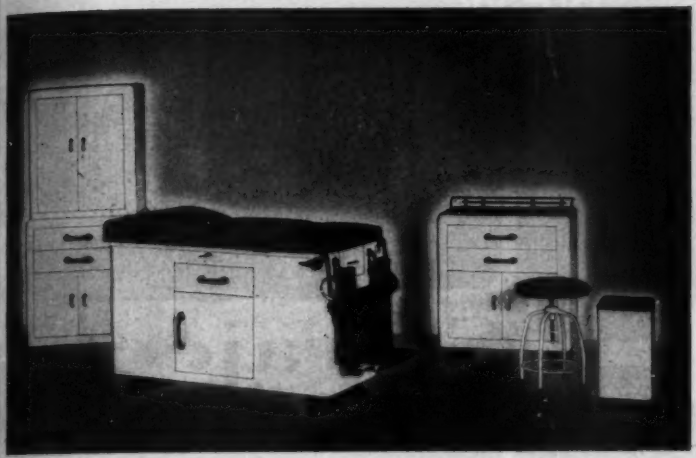

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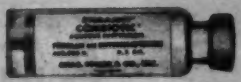

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How—and How Not—To Soundproof

[CONTINUED FROM 76]

ventilating system. If yours makes a racket, there are two things you can do about it: (1) install low r.p.m. fans and (2) insulate the ventilating ducts (they're sound ducts, too).

Many offices have hard-surfaced floors that act as sounding boards. The prescription for quiet underfoot is any resilient floor covering, like rugs, rubber tile, or cork. Other commonly overlooked noise-makers—that can easily be muffled—are squeaky doors, rattling windows, loud-flushing toilets.

Almost every noise problem can be licked. But before investing good money in what you think is the solution, consult an architect or acoustical engineer. Otherwise, you may spend a lot and get very little for it.

END

"Here, this ought to put an end to your misery."

M.D.'s Battle It Out With D.O.'s

[CONTINUED FROM 72]

president of the American Osteopathic Association) gave *their* ultimatum to the departing M.D.'s:

"Unless there is a move on the part of [the medical society] within the next twelve hours toward arbitration, all departments of City General Hospital will be staffed immediately by qualified physicians, surgeons, specialists, and technicians from osteopathic general hospitals through Michigan. Services will go on and people will be cared for regardless of the walkout of the medics."

The M.D.'s reply: "No arbitration at this time."

The osteopaths' deadline was Wednesday evening. When it had passed, they admitted their first patient (a medical case). The next day, with the help of their state society, the osteopaths installed their own staff. They admitted fourteen more patients, eight of them from out of town; and they scheduled seven operations for Friday.

Notwithstanding these admissions, the patient census on Thursday dropped to seventy-two. At Mercy Hospital, as the M.D.'s transferred their activities there, the number of patients went up from 245 to 260 and the operating schedule almost doubled.

Despite the exodus of the M.D.'s, the full staff of forty-five registered nurses stayed on duty at General Hospital. Pathologist W. G. Gamble, Jr., who owns the hospital laboratory equipment, also stayed to serve M.D.'s—but not osteopaths. X-ray technicians took X-rays for the osteopaths, but the regular staff roentgenologist refused to interpret them.

Since it was a public hospital, the disposition of emergency cases became important. On Tuesday, the M.D.'s had warned the police department that they would not be able to handle such patients at General Hospital. In that case, decided City Manager-Hospital Administrator Casimer F. Jablonski, "we will have to call on a doctor of osteopathy."

Battle of Words

For the most part, unhappy city officials took a hands-off position, watched the hospital's income dwindle, and waited hopefully for an early compromise between the two factions. For the time being, though, the D.O.'s and M.D.'s were too busy to talk compromise. Instead, they were issuing statements to the local press, each group blaming the crisis on the other.

To the osteopaths' charge that M.D.'s had refused to arbitrate before the city commissioners acted, President A. L. Ziliak of the medical society was quoted as replying that the M.D.'s had, in fact, suggested that the city might furnish separate facilities for the use of

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osteopaths. There had been no takers, he added.

The state osteopathic body backed up its local members by pointing out that "Osteopathic physicians and doctors of medicine are working together, harmoniously and successfully, in the same hospital in various other sections of the country." The inference: the medical men weren't "forced" into their walkout.

In addition to airing such charges and counter-charges on its front page, the Bay City Times treated its readers to an impromptu debate by the two schools over the theory of osteopathy and the standards of osteopathic colleges.

At the same time, the voice of the people began to be heard in the letters-to-the-editor columns. Perhaps because of editorial policy, these voices were about equally divided between those who found the M.D.'s action "disgusting" and those who felt as one citizen did: "Let's keep our hospital at the high level the M.D.'s have attained in the past."

When the weekend came, Bay City osteopaths were more or less on the defensive. Osteopath Spokesman Moore claimed that they were merely covering during the M.D. withdrawal, that they had wanted only limited facilities of their own. ("We are not trying to man a 154-bed hospital, and never have [tried].") The newspapers, thereupon, raised hopes of a compromise. But the hopes were quickly dashed by Dr. L. Fernald Foster, the hospital's chief of staff, who stated:

"We're not going to dicker with the osteopaths or anybody on a compromise situation until the air is cleared and the whole action of the city commission is rescinded."

City in Predicament

Thus city officials were on a hot spot that was daily getting hotter. Their hospital's census, even counting osteopathic patients, had dropped to fifty-two on Saturday. As a result, its daily receipts, which had averaged $2,300 per day during the previous month, were down to $900. Unless the city gave it a sizable contribution, the hospital would probably be unable to meet its next two-week payroll of $21,000.

The city commission was scheduled to meet next on the following Monday night. By that time, the hospital had virtually lost its nation-

al standing. Over the weekend, the American College of Surgeons removed it from the accredited list and the Michigan Hospital Association warned that it was being dropped from membership. Earlier, the A.M.A. Council on Medical Education and Hospitals had wired the local M.D.'s that "Hospitals admitting practitioners who [are not qualified medical men] are not eligible for registration or approval by the A.M.A."

At the commission meeting, which was jammed with spectators (many of them pro-osteopath), Commissioner Herman F. Techlin asked that the week-old resolution be reconsidered. This time, with Techlin changing his vote, the commission without debate defeated the measure five to four. The osteopaths were on the way out and the M.D.'s were back in.

At 5:33 o'clock the next morning the first M.D.-referred patient entered General Hospital. It was an emergency obstetrical case and it quickly added two new patients to the hospital's roll, which by then had sunk to twenty-five.

Why had Techlin changed his vote? His own reasons were: (1) "people are suffering from lack of medical care" and (2) "taxpayers were paying the whole shot for something from which they were not receiving any benefit." But he still had to meet accusations of yielding to M.D. pressure. One pro-osteopath commissioner bitterly attacked him:

"I don't know how the pressure of one group can get to one man and

Treatment in Absentia

● The small boy who had hobbled into my office with a painfully lacerated knee violently resisted my efforts to dress it. For these pediatric emergencies I keep a supply of Coca-Cola on hand, so I gave him a bottle to quiet him down. It seemed to do the trick.

But just as I began to wash the wound with peroxide, I was called to answer the telephone. When I returned, my mind still occupied with the call, I automatically picked up the cotton and bottle and went on swabbing the injured knee—until an indignant voice interrupted me:

"Hey, Doctor, what's the idea of using my coke!"

—LINCOLN P. ELAM JR., M.D.

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Because it's woven with live rubber threads—gives you far greater control of pressure

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change his mind from one week to another. But it is a fact that only one man was weak enough so that they could get to him."

D.O.'s Renew Fight

Despite their defeat, the osteopaths were not giving up their fight for hospital space. Following the commission meeting, Dr. Moore charged that the medical men "had demonstrated that [they] apparently can run the city, overrule the law, and overpower the city commission." His parting shot:

"The Bay County Medical Society has stated publicly on more than one occasion that it will negotiate for consideration of a separate unit . . . We will be interested to know if they will keep their word . . ."

The victorious M.D.'s, however, were not disposed to go on with the dispute unless their rivals goaded them into it. "Any continued bickering," warned Dr. Orlen J. Johnson, head of the medical society's special committee on the hospital issue, "is going to cost the taxpayers even more money."

Denying that they had ever offered to compromise on practicing under the same roof with osteopaths, the M.D.'s said they didn't object to the city's providing hospital quarters somewhere for the osteopaths. But it couldn't be at General Hospital where the osteopaths now had their eyes on the east wing for a 30-bed unit, complete with their own surgical and laboratory facilities.

[MORE→

"This has been happening pretty often, Johnson. Are these really emergencies, or are you just trying to beat the appointment book?"

The osteopaths were quick to move. "Failure of the M.D.'s to consider a settlement," said Dr. Moore, "leaves us with only one alternative –to take this to a vote of the people."

Two days after the commission's second vote, they began to circulate petitions for a referendum in the November election. The public would be asked to vote on a proposal to designate 20 per cent of General's bed capacity for osteopathic use. Late in July, Dr. Moore reported that the osteopaths had collected more than the required 1,400 signatures.

Threatened with this showdown by public vote, the M.D.'s are standing pat. According to Dr. Johnson: "The medical profession will not practice at General Hospital with the osteopaths under any circumstances, whether [the two groups are separated by] a brick wall, a fire wall, or anything else . . ." He explained this adamant stand to the city commissioners who were vainly trying to work out some new settlement: "You get kicked around just so long, and then you don't take it any more."

Reaping Bitter Fruit

Meanwhile, the M.D.'s who were trying to restore the hospital to normal, had inherited an aftermath of headaches. The patient census was slow in building up again, a fact that the M.D.'s attributed to "the undermining of public confidence in the institution." Even a month afterwards, the hospital, with only ninety patients, was still operating in the red; and sixty-three employes who had been laid off during Osteopath Week, were only gradually being re-employed.

Another setback for the M.D.'s was the news that reinstatement with the American College of Surgeons would not be merely a matter of form. The hospital had to be re-examined, the A.C.S. told them, and would be lucky to get back on the accredited list within a year.

In view of this backwash and the prospect of future trouble, what do the M.D.'s believe they accomplished by their walkout?

Says Dr. Johnson: "One thing is now perfectly clear to the public We have developed high standards of practice and ethics from which we will not deviate. We will not be subject to political maneuvers, nor be coerced into practicing with a sub-standard group."

Adds Dr. Ziliak: "We showed what the issue really boiled down to: that the M.D.'s will not go in with osteopaths and that the hospital can't run without M.D.'s."

On the other hand, they reaped an unwanted harvest of bitter feelings and distasteful publicity that may take them some time to live down. The Detroit Times, for example, lashed out editorially at the Bay City M.D.'s:

"Bluntly, the doctors of medicine are on strike against the hospital and their patients because they demand a closed shop for their particular doctors' union . . . Regardless

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1. Thorn, G. W., and Kendall, E., Jr.: in Harrison, T. R., ed. Principles of Internal Medicine, Philadelphia, The Blak Company, 1950, p. 697. 2. Gutman, A. B., et al.: Am. J. M 9:799, 1950. 3. Myers, W. K.: Am. Practitioner 3:158, 19 Talbott, J. H.: GP 5:38, 1952.

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of the merits of the battle between them, osteopaths have the same licensed rights as healers by state law as have the doctors of medicine ... The cause of medicine is not, we fear, being advanced by the Bay City boycott."

Moot Questions

One question the M.D.'s did not raise was that of the legality of the city commission's original decision. They merely held that the opposite decision would also be legal. But the Bay City Times commented:

"It seems that the action of the city governing body in favor of the osteopaths is a recognition of rights which could not have been reasonably withheld; and to which apparently they are legally entitled."

City Attorney Bernard S. Frasik pointed out that the M.D.'s, if they thought his legal opinion erroneous, could have got a court ruling without interrupting their work at General Hospital.

The Bay City Times, looking forward to the referendum in November, feels that it will be "meaningless." Even if "the plebiscite goes in favor of the osteopaths, the old school medics would still probably refuse to work with them ... A better solution must be found than that offered by the ballot box."

Meanwhile, the reaction of many citizens, caught in the middle of a medical tug of war, was summed up by a (pro-M.D.) city commissioner. Just after the city commission took back its idea of opening the hospital to osteopaths, he remarked:

"This quarrel between the two groups is a national question and Bay City certainly was not the place to settle anything. By doing so, we gained nothing. Instead, we spent a lot of good taxpayers' money."

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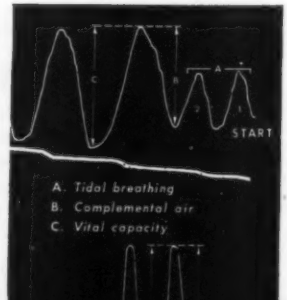

Upper Graph: Typical spirogram of asthmatic. Note marked diminution in vital capacity and complemental air; also, the overall lengthening of the interval between inspiration and expiration.
Lower Graph: This spirogram illustrates the improvement that may be expected in asthmatics following the administration of CORTONE. Note in particular the increase in vital capacity.

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"The patients' weight, fluid intake and output, blood pressure, and the results of the urine examination for sugar were charted daily . . . it was found that short-term therapy could be carried out safely for up to two weeks without extensive tests if there were proper cooperation between patient and physician and careful observation . . ."

Schwartz, E., *J. A. M. A.* 147: 1734–1737, Dec. 29, 1951.

Literature available

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The Interne Shortage And You

[CONTINUED FROM 93]

cians. Eighteen states require full citizenship, which entails a five-year waiting period. On the other hand, eleven state boards will not accept foreign physicians under any conditions.

Even when he's ready for examination it's almost an even bet that the foreign doctor will continue to fill an interneship for another year or so. Of 1,006 doctors from forty-seven countries, examined last year by thirty-five American boards, 482, or 48 per cent, failed to pass. In New York, where 448 were examined and 192 licensed, failures ran 57 per cent.

The majority of the unsuccessful candidates returned to interneships for further training and study before trying again.

Elizabeth's Twenty

Although the foreign interne has not been welcomed with unalloyed enthusiasm everywhere, very often —if he is available at all—he's the only alternative to doing without internes entirely.

Remarks Dr. Edgar W. Weigel, chairman of the interne committee of St. Elizabeth Hospital, Elizabeth, N.J.: "I've heard all the usual criticisms of the foreign interne, agreed with some, and added a few of my own. But I've never yet heard a good answer to the question: What on earth would we have done *without* him?"

Elizabeth (pop. 112,000) has three modern hospitals with 680 beds approved for interne training. None of the hospitals has had an American interne on its roster for at least three years.

Twenty foreign internes—six graduated in Germany, five in Great Britain and Ireland, three each in Italy and Poland, two in Rumania and one in Lithuania—make up the lack adequately, though not always to the complete satisfaction of all staff members. Training programs include weekly lectures by staff doctors. The rate of pay is $100 a month.

Some time ago Elizabeth's hospitals thought of strengthening their training programs, in the hope of attracting American internes, by arranging for supplementary teaching in New York. They found the cost prohibitive.

Superintendent W. Malcolm MacLeod of Elizabeth General Hospital, reports that his nine foreign internes are satisfactory. "We'd be happier with a few American internes. But as it is, none of our 180 staff doctors has to do internes' work. Meanwhile, the competition for good foreign internes is getting tougher. What our situation will be in two or three years is anybody's guess."

Helpful as he may be, the foreign

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an unsurpassed pediatric antihistamine

Pyribenzamine® Elixir

A palatable, spice-flavored antihistamine, Pyribenzamine Elixir offers highly effective therapy in a broad range of allergies. *Dosage can be readily adjusted* to suit age, any individual requirement. *Prescribe this well-accepted medication* alone or as a therapeutic vehicle. Each 4 cc. (approximately one teaspoonful) contains 30 mg. Pyribenzamine (tripelennamine) citrate (equivalent to 20 mg. Pyribenzamine hydrochloride). In pints and gallons.

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interne will never solve the problems of the shortage. The current influx of exchange students is inadequate and promises to remain so, even though its volume may be stepped up somewhat.

The Immigrant Interne

As for the immigrant physician, he's pretty much a localized phenomenon, seldom venturing far from the largest cities. Furthermore, his numbers are decreasing; fewer are coming to America, and eventually all but a handful will be licensed practitioners or else will have quit trying and turned to other fields.

The National Committee for Resettlement of Foreign Physicians, a non-sectarian organization supported by the United Jewish Appeal, lists in its files most, but not all, of the foreign doctors who have come to the U.S. in the last fifteen years. It has helped place 7,000 of them since 1938. It now registers about twenty-five new arrivals a month, directing most of them to internships.

Fifty per cent of the interneships now being filled by these doctors are in the New York metropolitan area and New Jersey; 30 per cent are in the Midwest, mostly in and around Chicago; and the remaining 20 per cent are scattered.

It's a hard, grim fact that a good many hospitals are going to have to get along without internes for some years to come. But it doesn't necessarily follow that *your* hospital must be one of them. You can't do much about the general situation, but you may relieve your own need somewhat by noting the ways in which some non-teaching hospitals have held their own in the competition.

Hackensack (N.J.) Hospital offers a shining example of how a medium-sized hospital *can* attract both American internes and the most desirable of the foreign-trained candidates. With 250 beds and a new wing going up to house 110 more, it operates a training program that rates high with medical school deans and has never failed to attract some of their senior students.

Hackensack tried for twelve internes in the matching plan, was matched with seven, and wound up finally with six. It has made up the deficiency with five carefully chosen foreign internes—three women and two men—from Germany, Italy and Korea. Three others, expected from England, failed to show up. The

"Take one pill five times a day."

hospital has, in addition, four residents and three unfilled residencies.

Dr. Spencer T. Snedecor, chairman of the interne-resident committee, could use two or three more internes, but concedes that things aren't too bad with the eleven on hand.

"We're in better shape than many hospitals in this vicinity," he says. "We ought to be. Our program represents a lot of hard work by the committee, by most of our 150 staff members, and by the hospital administration. It costs around $40,000 a year—more than many smaller hospitals can afford—not counting time, effort and intangibles that don't wear price tags.

"Money and effort are the first requirements for a good interne set-up. The hospital that can't or won spend the one, and the staff th won't contribute the other, a bound to have trouble."

Dr. Snedecor's hard-workin committee includes a paid "coordi ator", a young doctor who receiv $1,500 a year for running the ed cational program. Besides schedu ing twice-a-week lectures by sta members, it's his job to bring in le turers from the New York teachin centers.

There's a committeeman to ha dle the internes' rotating assig ments, and another in charge of th library. Too many hospitals, th committee feels, overlook the impor tance of maintaining a first-rate l brary and a competent librarian.

Finally, there's a physician wh

PROVEN—

for greater carbohydrate alimentation

10% Travert® SOLUTIONS

(INVERT SUGAR)

for twice the calories of 5% Dextrose

in equal infusion time

with no increase in fluid volume or vein damage

With *10% Travert* solutions, a patient's carbohydrate needs can be more nearly satisfied within a reasonable time with no increase in fluid volume or vein damage.

Travert solutions are sterile, crystal-clear, colorless, non-pyrogenic and non-antigenic. They are prepared by the hydrolysis of cane sugar and are composed of equal parts of D-glucose (dextrose) and D-fructose (levulose).

Travert solutions are available in water or saline in 150 cc., 500 cc., 1000 cc. sizes. For the treatment of potassium deficiency, *10% Travert* solutions with 0.3% potassium chloride are also available in 1000 cc. containers.

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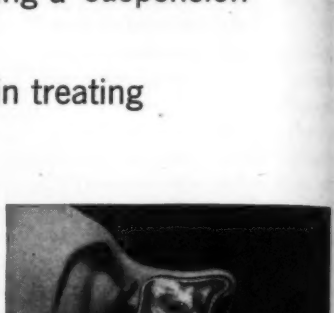
GENERAL OFFICES • EVANSTON, ILLINOIS

Why physicians are using a suspension rather than a solution in treating intranasal infections...



Paredrine*-Sulfathiazole Suspension

Vasoconstriction in minutes
Bacteriostasis for hours

- unlike antibacterial agents in solution, does not quickly wash away. It actually deposits bacteriostatic crystals on the infected mucosa. *There they remain in intimate contact with the infection*—the most important reason why so many physicians find the Suspension strikingly effective against nasal infections and sore throat.

*T.M. Reg. U.S. Pat. Off.

Smith, Kline & French Laboratories, Philadelphia

plans and directs social activities. He's responsible for making each year's class of internes feel at home and for fostering an *esprit de corps* –which means that his province extends to all hospital personnel and staff members.

Most of the American internes at Hackensack rated the hospital tops on their matching lists after a preliminary visit. They're paid $100 a month, in addition to maintenance, plus a $25 monthly bonus. The bonus, payable at the end of the twelve-month term, is forfeited by any interne who leaves the hospital before then.

Hackensack Hospital is typical of many others, its size or larger, that consistently attract American internes, though not always in sufficient numbers. In most such nonteaching hospitals, internes are given more responsibility and have a relatively higher status than in crowded teaching institutions. Where the outlook for residencies and staff appointments is also favorable–and where the training program is above average–the interne shortage may be troublesome, but it is seldom desperate.

What Doctors Can Do

What can the individual doctor do when he finds himself working harder, or foresees that unwelcome prospect, because his hospital has too few or no internes?

That depends.

If his interne committee is lackadaisical . . . if the superintendent is worrying too much about other

problems and not enough about this one . . . if the board of trustees isn't properly impressed with the importance of keeping interneships filled —then, perhaps, the doctor can do something to start these people thinking and acting more effectively.

"Interneship has changed tremendously in our time," Dr. Leveroos points out. "It's no longer the stepping-off point for the young doctor, the capstone of his education, and the gateway to practice. Usually it's an abbreviated transitional stage between school and residency—and a relatively unimportant stage unless the most is made of it.

"In some big teaching hospitals the interne, squeezed between junior and senior clerks on the one hand and residents on the other, may be virtually lost in the shuffle. Many students, realizing this, would prefer smaller hospitals if they could be assured of good training."

Often a little more money and a little more inspired effort can transform a moribund interne program into a good one. A thorough reassessment and clear presentation of the hospital's tangible and intangible assets, from the interne's point of view, may discover attractions not clearly visible before.

To influence the law of averages in your favor, doctors who have studied the problem recommend the type of interne program *you'd* like to serve in if you had to do it over again. END

"A fortune teller told me I'd meet someone like you!"

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DEPENDABLE

Constant improvements to meet the latest medical demands have kept it one of the finest multivitamin products available.

Doctors throughout the nation report better results with

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TWO TABLETS (average daily dose) standardized to contain:

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A	5,000 USP units
D	800 USP units
C	100 mg.
E	0.2 mg.

COMPLETE B COMPLEX

B_1	5 mg.
B_2	5 mg.
Niacin and Niacin Amide	30 mg.
B_6	0.2 mg.
B_{12} (50% USP Crystalline / 50% B_{12} Concentrate)	1 mcg.
Panthenol	4.3 mg.

Also other members of the B Complex from natural sources, yeast and liver fraction 2

MAINTENANCE MINERALS

Iron	15 mg.
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TRACE MINERALS

Cobalt	0.2 mg.
Copper	0.75 mg.
Manganese	1 mg.
Zinc	0.5 mg.

LOW IN COST TO PATIENTS

Available at all pharmacies

Especially suitable in pediatrics and geriatrics: The Stuart Formula Liquid, a pleasant-tasting, easily-administered liquid, containing A, D, B_1, B_2, B_6, Niacin, Niacin Amide, Panthenol, including entire B Complex, minerals, malt and rice polish concentrate.

How About a Business On the Side?

[CONTINUED FROM 83]

state got in on the ground floor. He spent close to $10,000 for a dozen mated pairs, another $3,000 for sheds and equipment. And now he's selling breeding stock to other would-be-fanciers. Last year, he proudly reports, he got his loss down to less than $1,000.

An M.D. who owns one-sixth of a prizefighter has lost even less. He got his share of the boxer in payment for medical services rendered the man after an unfortunate pasting. So far, the fighter's training expenses have cost the doctor only about $400.

Wherever you do find success in a venture that's not primarily real estate, there's usually a fluke to explain it. For instance, one retired physician now lives comfortably in Florida on an income of $9,000 a year from an orange grove that cost him $23,000. He happened to buy just before the frozen juice concentrates were developed. But those who have bought since—at inflated prices—aren't doing nearly so well.

Why Doctors Lose

Other men profit from farms, motels, and automobile dealerships. Why, then do *doctors* always seem to lose when their side excursions take them outside of real estate?

There are three basic explanations for their hard luck:

1. The physician is peculiarly a magnet for unsound propositions. He's popularly supposed to have money to invest. And his intimate relationshp with patients not only acquaints him with their schemes but—psychologically—also lowers his guard.

2. The very fact that a doctor is so highly trained in medicine means that he has had little time to learn the fine points of business. Though he can always hire managerial help, the ultimate decisions must be his own.

3. No matter how capable a businessman he is, a physician rarely has the time available that an independent business demands.

But despite the poor showing physicians generally have made as businessmen, you may still think that *you're* the exception who can beat the game. If so, the following rules-of-thumb may help keep trouble away:

¶ Make *sure* you can spare the cash and the time from your practice.

¶ Talk with your banker, a business broker, or a management consultant about the strength and prospects of any contemplated business.

¶ Avoid businesses that have any connection with medicine. They may be perfectly proper, but there's always the chance they may involve you in a breach—or seeming breach—of ethics. END

The Newsvane

A.C.S. Further Clarifies Stand on Fee Splitting

Surgeons around the country are once more examining their collection methods to determine whether or not they could be considered guilty of fee splitting. In its latest official clarification of the subject, the American College of Surgeons has gone on record as "unalterably opposed" to the following practices:

1. Payment by the surgeon of an "inducement" to the referring physician, in the guise of an excessive assistant's fee;

2. Presentation of an unitemized combined bill by two unassociated physicians.

Both practices were taken under consideration some months ago by the A.C.S. professional relations committee under Dr. Warren H. Cole. The committee at that time branded the assistant's fee as out-and-out fee splitting when the referring physician is chosen as assistant in preference to regular assistants or anesthetists when available. The unitemized combined bill was designated as questionable, because it might camouflage fee splitting; but the A.C.S. has now definitely termed it unethical. Says the college:

"The essential of ethical financial relations in the medical profession is simply honesty, which requires the patient to be informed of the amount . . . due to each physician for services rendered." Thus its latest ruling is apparently designed to scotch even the faintest possible hint of collusion between referring physician and surgeon.

Even when they present the patient with a combined bill, frankly sharing the fee, they must, according to the A.C.S., observe two precautions:

1. The bill must be itemized to show the services of each, unless the two doctors are "formally associated."

2. The combined charges must not be "out of proportion in any item to the individual services rendered."

New Hill-Burton Figures Show Good Progress

The Federal Government is nearing the half-billion-dollar mark in grants for hospital construction under the Hill-Burton program. What's being done with all this money? The Public Health Service has drawn up this progress report on the first five years of the program's operation:

¶ About 850 new hospitals and

community health centers have been completed and are in operation, adding 30,000 beds to the nation's total. Another 950 projects—with 55,000 beds—are in various stages of construction. Total cost: nearly a billion and a half, of which $480 million has come from the U.S. Treasury.

¶ Most of the new institutions are general hospitals located in small communities, usually where no prior facilities existed. More than half are situated in Southern states.

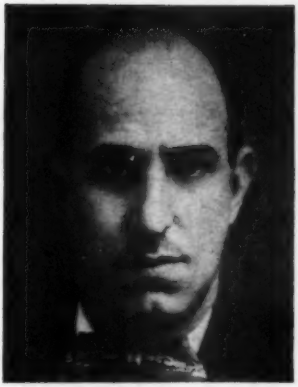
¶ The new hospitals are relatively small, 57 per cent having fewer than fifty beds apiece. (Only 20 per cent have more than 100 beds.)

But the gains under Hill-Burton are said to be slight when compared with the nation's needs: State hospital officials estimate the deficit at an additional 850,000 beds.

Are Surgeons Victims Of Own Publicity?

On the seldom-quiet battlefield of surgical privileges, an attack usually precipitates a counterattack. Recently, for example, when Dr. Evarts Graham of St. Louis, a member of the President's Commission on Health Needs, let loose a salvo to the effect that G.P.'s should do no surgery, he promptly drew a barrage from the G.P. encampment. Writes Dr. Paul Williamson of Memphis, in a letter to the editor of the journal, GP:

"Ordinarily, such statements are those of jealous men who revolt upon facing the truth that the general practitioner does by far the majority of all surgery. When an acknowledged leader in medicine claims that the general physician has no ability . . . rebuttal becomes necessary.



Paul Williamson
Surgeons are over-glamorized

"The factual content of all such statements is simply that the general practitioner should not do surgery because he is incompetent to do so . . . We should admit that some general practitioners are incompetent. So are some surgeons. [But] *all* of us *cannot* be.

"In show business . . . the one fatal thing . . . is to begin to believe [your] own publicity. Surgery has been glamorized beyond all reason . . . Could operative surgery have been glamorized to such an extent that surgeons have begun to believe their own publicity? [MORE→

"All of us would agree that surgical experience is necessary to make a good surgeon: I would, however, ask: Does there live a great enough egotist to say, 'There is but one way to get this experience, and that is the way I say it must be done?' Formal training is but one way of giving capsulated surgical experience. Could there exist a man so narrow as to say there is no other way?

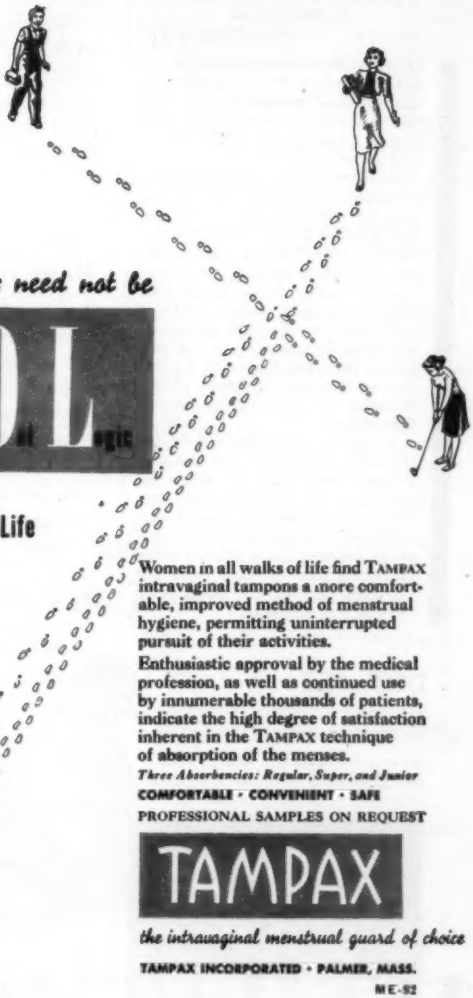
"Shall the doctor police his own work and set his own limitations or shall he depend upon a board of 'guild supervisors' who may be swayed, not only by his skill, but by whether openings exist in the guild and by the many other unfortunate human elements which so accurately and so frequently reflect man's inhumanity to man?

"When heady adulation comes his way (as it will) may the general practitioner remain a humble public servant and find time to worry about his own competence—not the competence of others."

Rx Business Booming, Druggists Report

Doctors wrote nearly 238 million prescriptions last year, almost 2 per cent more than in the record-breaking prescription-writing spree of the previous year. These, plus refills, gave druggists a total of 397 million prescriptions to fill—likewise an increase of 2 per cent.

With this slight boost in volume, however, the cost to patients of all prescriptions in 1951 ($746 mil-



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All Walks Of Life

Women in all walks of life find TAMPAX intravaginal tampons a more comfortable, improved method of menstrual hygiene, permitting uninterrupted pursuit of their activities.

Enthusiastic approval by the medical profession, as well as continued use by innumerable thousands of patients, indicate the high degree of satisfaction inherent in the TAMPAX technique of absorption of the menses.

Three Absorbencies: Regular, Super, and Junior

COMFORTABLE • CONVENIENT • SAFE

PROFESSIONAL SAMPLES ON REQUEST

TAMPAX

the intravaginal menstrual guard of choice

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ME-52

lion) rose 15 per cent over the 1950 figure. Why?

"Simply a reflection of . . . revolutionary . . . changes in the types of medicines prescribed," says Drug Topics, the national newspaper for retail druggists, in reporting on its thirteenth annual prescription survey.

Court Puts Brake on Malpractice Suits

A recent decision of the U.S. Circuit Court may tend to reduce the number of medical malpractice suits by making plaintiffs—however sincere—think twice before going to court. Like Nicholas Di Vincenzo, they will find that a suit can be an expensive proposition, now that the costs can't be written off as tax losses.

Some time ago, Di Vincenzo's daughter died while under treatment. Di Vincenzo then brought suit against the doctor, charging malpractice. Later on, he took a tax deduction for the legal fees he had

Anecdotes

¶ MEDICAL ECONOMICS will pay $10-$25 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice.

Medical Economics, Inc.
Rutherford, N.J.

The *Gentarth* formula constitutes a new, direct approach for relief of pain and reduction of swelling and joint inflammation in rheumatoid arthritis. *Gentarth* is non-hormonal in action.

Sodium gentisate has been found to produce favorable results in both rheumatoid arthritis and acute rheumatic fever,[2] possibly because of its inhibiting effect on the hyaluronidase in synovial cavities.[3,4] Inclusion of salicylate, as in the *Gentarth* formula, provides additional analgesic action and enhances effectiveness.

Gentarth tablets also contain succinic acid to protect against increase in prothrombin time—a necessary precaution in prolonged salicylate therapy.

Each tablet contains:

Sodium Gentisate	100 mg.
Raysal . . . . . (*representing 43% Salicylic Acid and 3% Iodine in a Calcium-Sodium Phosphate buffer salt combination*)	325 mg.
Succinic Acid	130 mg.

Dosage: 2 to 4 tablets 3 or 4 times daily (after meals and before bedtime).

Supplied in bottles of 100, 500 and 1,000. Available through all ethical pharmacies.

1. *Boyd, L.J., Lombardi, A.A. and Seigals, C.: New York Med. College Bull.*, 13:91, 1950.
2. *Meyer, K. and Ragan, C.: Mod. Concepts of Card. Disp.*, 17:2, 1948.
3. *Quick, A.J.: J. Biol. Chem.*, 101:475, 1933.
4. *Guerra, J.: J. Pharm. Exper. Ther.*, 87:1943, 1946.

Serving the medical profession for nearly a third of a century

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PHARMACAL COMPANY Pharmaceutical Manufacturers
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to restore
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"The best results were obtained in patients . . . treated with sodium gentisate and salicylate"[1]

Tablets

GENTARTH

The original preparation containing sodium gentisate, an inhibitor of the spreading factor enzyme, hyaluronidase

paid his lawyers, listing them as "losses" on his return.

When the Bureau of Internal Revenue ruled that the deductions were not permissible, Di Vincenzo appealed to the Tax Court and, when turned down there, to the Circuit Court of Appeals.

But the Circuit Court has also ruled against him. Di Vincenzo, says the Court, did not take his loss "within any exemption or deduction allowed by the tax law."

Former Patient-Load Peak Becomes Plateau

Doctors nowadays are almost as rushed as they were during World War II, if physicians of western Pennsylvania are a fair sample. Ten years ago, the average civilian doctor's patient load was considered backbreaking. But now an equivalent load has become daily routine, according to a study of the situation undertaken by statisticians of the Graduate School of Public Health, University of Pittsburgh.

In western Pennsylvania, the study shows, the average G.P.'s patient load is 107 different individuals a week. He sees about three-fourths of his patients (eighty-three) in his office. Of the rest, he visits sixteen at home, eight in the hospital.

The fully specialized practice creates a lighter patient load, the statisticians find. The weekly number of patients for specialists ranges from the pediatrician's ninety-nine to the neuropsychiatrist's forty. An exception is the EENT man, who

New **Steroid-Vitamin-Mineral**

Tablet

COVISTEN

Your patients—young or aged—who need steroidal-nutritional support will have it in a single tablet when you prescribe Covisten. For the young, Covisten will prove invaluable as an anabolic tool—for the aged, an excellent way to supplement waning gonadal function and diminishing intake or utilization of foodstuffs. Covisten supplies Stenediol® (methyl androstenediol—the non-virilizing androgen which imparts the 'lift' unique with steroids) plus vitamins plus minerals in balanced combination.

Each tablet supplies:

Stenediol (methyl androstenediol)	5 mg.
Ascorbic acid	50 mg.
Thiamine HCl	2 mg.
Riboflavin	3 mg.
Pyridoxine HCl	1 mg.
Vitamin B_{12}	2.5 mcg.
Niacinamide	20 mg.
Folic Acid	0.5 mg.
Vitamin A	5000 U.S.P. Units
Vitamin D_3	500 U.S.P. Units
Ferrous Gluconate	75 mg.
Dibasic Calcium Phosphate	200 mg.
Manganese Hypophosphite	0.5 mg.
Dibasic Magnesium Phosphate	20 mg.

Bottles of 100 & 1000

Organon INC. • ORANGE, N. J.

T.M.—Covisten

sees 112 patients a week—even more than the G.P.

These findings, published recently in Public Health Reports, are based on a questionnaire that got a 34 per cent response from the doctors in active private practice in the twenty-seven westernmost counties of Pennsylvania. Figures apply to practice during a typical week in October, 1950.

The survey, made by Antonio Ciocco, head of the graduate school's biostatistics department, with the aid of two associates, doesn't explain why wartime-size patient loads are burdening the medical profession now. On the contrary, it demolishes a couple of explanations that have been used rather often:

¶ Is the heavy patient load due to a scarcity of doctors in certain areas? Hardly, says the report. It shows that patient loads vary little from county to county according to the relative number of physicians.

¶ Is prosperity a factor, in that it enables patients to pay for abundant medical attention? Again the statisticians say no: "Low patient loads are found in both wealthy and poor counties."

Whatever the explanation, the study finds the well-crammed schedules of western Pennsylvania reminiscent of peak patient loads in wartime Georgia, Maryland, and the District of Columbia. It notes that when a 1945 nose count showed District of Columbia G.P.'s struggling with a weekly average of 138 patients, the local medical society regarded the situation as crucial

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improved

ARLCAPS

for faster, greater,
more sustained relief
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hay fever and the common cold

- reduces edema and congestion in the bronchi and upper respiratory mucosa – relaxes spastic bronchial musculature.
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each capsule provides:

Ephedrine Hydrochloride	25 mg. (2/5 gr.)
Ascorbic Acid	100 mg.
Aspirin	130 mg. (2 gr.)
Phenobarbital (may be habit forming)	26 mg. (2/5 gr.)

now contains ascorbic acid

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The self-conscious acne patient, whether male or female, cooperates more readily when Almay preparations are prescribed in a matching complexion shade.

for the comedones

RESULIN

(Almay Resorcin and Sulfur Compound)

a superior compound for acne therapy.

LOTION: *Regular* (full) *strength* for severe cases, thick and oily skins . . . or *modified* (half) *strength* for tender skins or to determine tolerance in new cases. Available in blonde or brunette shades—bottles of 4 fl. oz.

OINTMENT: For day-time masking of lesions, and for more rapid penetration . . . washable. Blonde or brunette shades—tubes of 1½ oz.

SOAP: With salicylic acid—cake 4 oz.

for the scalp

RESORCITATE (Almay Lotion Salicylic Resorcinol Monoacetate Compound):
Plain—for oily hair . . .
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ALMAY SULFUR FACE POWDER: Sulfur content 5% . . . perfumed.

ALMAY GREASELESS CREAM: For very oily skins . . . perfumed or unscented.

Resulin samples on request.

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Division of Schieffelin & Co.
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for Acne . . therapeutic efficacy plus cosmetic elegance . .

RESULIN

yet Pennsylvania G.P.'s today are matter-of-factly handling about 80 per cent as many without turning in any alarms.

'Progressive Conservatism' Urged on Physicians

Physicians who try to make the public believe that our present system of medical care is flawless are politically blind, says a doctor who knows his politics well—Representative Walter H. Judd, of Minnesota.

Urging doctors to become "political economists as well as medical diagnosticians," Representative Judd recommends a middle-of-the-road course. "We medical people," he says, "tend to concentrate on the fact that 75 per cent of the people have good [medical] care. The professional reformers concentrate on the fact that 25 per cent don't . . ."

He likens the situation to a glass three-quarters filled with water. "The reformer would say of the glass, 'It's no good because it isn't full.' He would throw out the three-fourths and start with nothing. We're inclined to say that the system is all right, because the glass isn't empty."

Doctors should not be radicals "who would destroy what we have because it isn't perfect," says Judd; but neither should they be reactionaries, "who [say] it's good enough because it's better than anybody else has.

"What we ought to be, as our forefathers were, is progressive conservatives. Conserve the things that enabled us to get that 75 per cent . . . but, at the same time, progress so as to expand the good to 85 per cent, then 95 per cent, and so on. If we don't, the radicals will come in and take over."

Walter H. Judd
A lesson in a glass

New Hospitals Have Their Headaches, Survey Finds

New hospitals mushrooming over the country are attracting doctors to areas hitherto medically underprivileged. But these hospitals are also, in a few cases, suffering from administrative troubles. This is the story behind the statistics of a recent survey made by the Texas State Department of Health.

Under the Hill-Burton Act, thirty-four new institutions and sixteen annexes or enlargements have been

added to the Texas roster of hospitals; and, according to the survey, some of them are now facing problems that might daunt even more experienced institutions.

One result: a turnover of twenty-one administrators in fourteen hospitals in little more than a year.

The inexperienced, uninformed, or inert governing board is cited as a frequent source of trouble. The board and staff physicians must split the blame, according to the survey, for such problems as these:

¶ Doctors on the board dictating policy. In four of the hospitals, at least one active physician is a voting member of the board. In three, hospital policy is apparently set by a single physician—probably because of the inexperienced governing board.

¶ Doctors carrying on their office practices in hospitals. In four new Texas institutions, doctors have set up offices. In one instance, a new physician moved into a previously doctorless community and opened an office in the county hospital without even getting the board's permission. Taking advantage of the inexperienced board membership, he brought in his wife as laboratory technician and unofficial administrator. He even discharged patients at will without notifying the business office. When the board finally tried to evict him, loyal patients petitioned the county court to protect the doctor and dismiss the board. The troublemaker moved out—and built his own clinic across the street. His building was so superior

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Dicalet tablets t.i.d.
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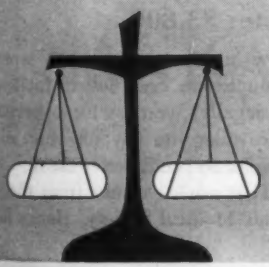
Vitamin B_1	1.5 mg.	100%
Vitamin B_2	3 mg.	100%
Nicotinamide	15 mg.	100%
Vitamin C	150 mg.	100%
Iron	15 mg.	100%
Calcium	1500 mg.	100%
Phosphorus	1500 mg.	100%
Pyridoxine	1.5 mg.	**
Vitamin B_{12}	3 mcg.	**
Folic Acid	1.2 mg.	**
Cobalt	0.3 mg.	.....
Copper	3 mg.	.....
Iodine	0.45 mg.	.....
Magnesium	18 mg.	.....
Manganese	3 mg.	.....
Potassium	15 mg.	.....
Zinc	3.6 mg.	.....

‡Recommended Daily Dietary Allowance for Pregnancy and Lactation, NRC. In pregnancy 1200 cal., in lactation 2000 cal.
**—need not yet established.



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ABBOTT

to the hospital itself, the survey reports, that hospital occupancy dropped to 10 per cent.

Six other cases of physicians or groups that have erected clinics across the street from new hospitals are cited by the survey.

On the credit side, however, it notes that thirteen of the Hill-Burton hospitals in Texas have lured new doctors to settle in their respective communities. In two of these places there had previously been no active physician.

More than half the surveyed hospitals supplement their local staffs with visiting specialist-consultants, who travel twenty to 120 miles for periodic visits. Two hospitals still have no qualified surgeon on the staff. In about one-third of the new institutions every staff man does major surgery.

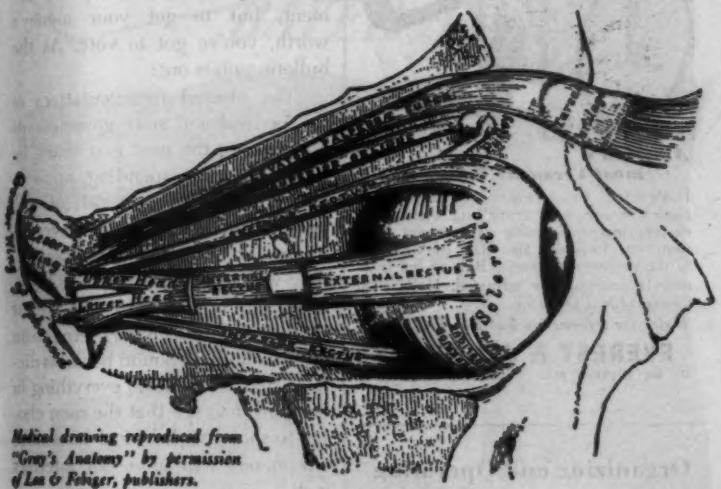
Occupancy figures indicate healthy growth, according to the survey. The median occupancy for the second half-year period of operation was 43 per cent—4 per cent higher than that for the first six months. In one hospital, occupancy jumped more than 66 percentage points, to 119 per cent.

Price Tag on Your Vote: $3,800

How much is your vote worth? Though you can't sell it (at least, not legally), you pay for it—perhaps more than you pay for your automobile. So you'd better use it.

That advice comes from the St. Louis Medical Society. Here's how

When a patient just can't see giving up coffee . . .



Medical drawing reproduced from "Gray's Anatomy" by permission of Lea & Febiger, publishers.

Tell him about grand-tasting Sanka Coffee. It's 97% caffein-free . . . can't cause sleeplessness or get on the nerves.

SANKA

The perfect coffee for the patient affected by caffein.

Products of General Foods

the society's bulletin reasons it:

If you buy a new car, you devote plenty of time and study to its selection, because an automobile is a major investment and you want to get your money's worth. Sound, efficient government is also a major investment, but to get your money's worth, you've got to vote. As the bulletin points out:

"The elected representatives of the Federal and state governments will, during the next two years, be responsible for spending approximately $156,000,000,000 of the people's money. For the average American family of four persons, they will spend in excess of $3,800. This amount represents the largest single item in the average American family's budget. Sound business dictates that we each do everything in our power to see that the men chosen to spend such a large amount of our money will serve our interests well."

'Cancer Clinics Must Stop By-Passing Physicians'

The nationwide cancer detection program has been by-passing the doctor and dealing directly with patients, presumably to extend its usefulness. Yet its "yield of detections [has been] disappointingly low." So the clinics may as well be reorganized completely, to cooperate with practitioners as well as patients. That's the conclusion of at least one observer, Dr. W. S. Reveno, an editor of the Detroit Medical News.

At first, he concedes, he had high

The Makers of Bayer Aspirin Announce....

NEW *FLAVORED* CHILDREN'S SIZE *BAYER ASPIRIN*

The Best Tasting Aspirin You Can Prescribe.

2½ gr. 1¼ gr. Grooved Tablets—Easily Halved.

The Flavor Remains Stable Down to the Last Tablet in the Bottle.

24 Tablet Bottle... 2½ gr. each 15¢

Professional samples of the new *Flavored* Children's Size Bayer Aspirin are now in the mail. Additional samples will gladly be supplied on request.

THE BAYER COMPANY DIVISION of Sterling Drug Inc.
1450 BROADWAY, NEW YORK 18, N. Y.

Children take it without the least bit of fuss

Swallowed Whole

Chewed Like Candy

Dissolved on Tongue

Or in Food Or Liquid

hopes that the cancer clinics "might explore avenues not open to the practicing physician." But the hopes haven't materialized. "Aside from the cervical smear, the examination is no more revealing than that made in any physician's office." Nevertheless, he finds, patients cherish a false impression that a negative report from a cancer detection clinic is conclusive.

Change the clinics drastically, Reveno urges, so that they start "supplementing, not duplicating the facilities for cancer detection now available in the physician's office." For example, he'd have them:

¶ Operate as referral centers;

¶ Seek and find the inadequacies in present-day detection efforts;

¶ Pass useful information along to doctors.

Thus "the cancer detection program can be made to mean something," he believes.

Says High Fees Not Major Cause of Grievance

What makes patients complain about fees? Curiously enough, it's often not the size of a bill that matters, nor do moderate fees guarantee immunity to fee complaints. Instead, most fee protests are based on complaints that the physician hasn't modified his usual fee to fit an unusual case.

This is the finding of the Mediation Committee of the Wayne County (Mich.) Medical Society, which can claim as much experience with fee squabbles as any oth-

FOUR SPECIAL, VALUABLE SERVICES FOR DOCTORS

Offered By H. J. Heinz Company

Realizing that the health and welfare of present and future generations depends vitally on proper nutrition, H. J. Heinz Company—in addition to preparing quality foods—regards the fields of food research and education as part of its responsibility. So these four complimentary services are made available to you doctors to help in your laboratory and office work as well as in your contacts with patients!

SPECIAL SERVICES FOR LABORATORY AND OFFICE USE

NUTRITIONAL DATA—This authoritative reference book on foods and nutrition—complete with convenient tables and charts—is used in 95% of the nation's medical schools. Have you *your* copy of the revised 13th edition?

NUTRITIONAL OBSERVATORY—Published quarterly, this informative magazine summarizes outstanding current articles on nutrition, selected from the scientific and medical journals of the world. Are you on the mailing list?

SPECIAL SERVICES FOR YOUR PATIENTS

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BABY FOOD GIFT FOLDERS—These attractive coupon books—designed for presentation to mothers—are redeemable at grocery stores. They make welcome gifts—save need for office samples. Are you well supplied with folders?

HEINZ BABY FOODS

Heinz prepares a full line of quality Baby Foods—including Pre-Cooked Cereals, Strained Foods and Junior Foods. Because of their outstanding flavor, color and texture, these foods are recommended everywhere by Physicians, Pediatricians, Geriatrists, Stomach Specialists and Dentists.

Send In This Coupon Today!

H. J. Heinz Co., Baby Foods
Dept. ME-9, Pittsburgh, Pa.

Please mail me the Heinz special services which I have checked.

- ☐ Nutritional Data
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Name_____

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City_____ Zone____ State_____

er committee in the field. Its current report analyzes the sixty-eight complaints investigated last year (incidentally, about 50 per cent more than in previous years).

The OB fee, since it is ordinarily a flat charge, causes the greatest trouble, says the committee. In some cases, the patient *demands* the flat fee, instead of a higher charge for extra care due to complications. In other cases, she *objects* to the flat fee, usually because the obstetrician was not present at the birth. Though recognizing that a physician's absence is sometimes unavoidable, the committee voices a reminder: The patient regards the delivery as the main event of OB care; if the doctor fails to show up for it, she feels entitled to a refund, "and a large one," too.

Other typical grievances:

¶ The physician skimped on the time allowed for an office visit. (Patients are particularly indignant if the skimping cuts short a diagnostic examination.)

¶ The physician himself did not perform the services, leaving them to his assistant or nurse.

¶ The treatment was not successful. A typical wail quoted from an allergy patient: "For shame that the doctor should bill me while I still itch!"

Some people, the committee warns, are irritated merely at the method of billing, no matter what the amount. One patient protested a bill because it arrived in allegedly indecent haste, within twenty-four hours of services rendered. Another


Camels
lead all
other brands
by billions
CAMEL
CAMEL
CAMEL
CAMEL
CHOICE QUALITY
CAMEL
TURKISH & DOMESTIC BLEND CIGARETTES

objected that a bill came too l... four years after the service.

The upshot of all these gripes ... one-fourth of them the commit... sided with the patient, and phy... cians voluntarily reduced charg... Half were rejected as without fou... dation. In some of the rejected ca... physicians offered to adjust th... fees anyway, for the sake of go... will; but the committee restra... them, warning that patients sho... not be allowed to profit from bl...

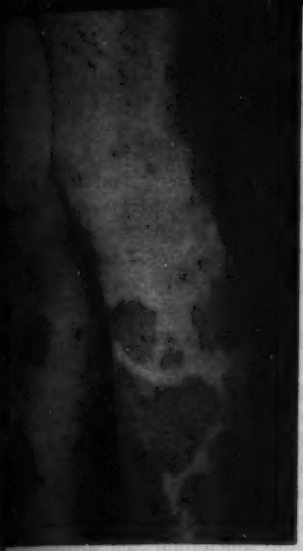
Doctors and Co-op End Twenty-Year Feud

After more than two decades ... feuding, fussing, and fighting, Bec... ham County (Okla.) doctors ... the Elk City Community Hospi... the country's oldest health coop... tive, have finally come to terms.

In exchange for certain conc... sions by the hospital co-op, th... county medical society has agre... to admit the co-op's staff physici... to society membership. Refusal ... membership was the main issue th... prompted the co-op to file a lawsu... against the society in 1950. The su... still pending at the time of th... agreement, has now been dropp...

The medical society bucked th... co-op, according to the latter, b... cause its prepayment plan ... counter to the doctors' traditio... fee-for-service pattern. But the s... ciety gave different reasons fo... opposition. It contended that:

1. The Elk City Community H... pital plan prevented free choic... physicians. [illegible]



Before Use of Riasol

After Use of Riasol

When Birds Fly South PSORIASIS patients need RIASOL

The approach of colder weather is a warning that psoriasis eruptions will soon return to many of your patients who have enjoyed summer remissions. In this connection, here are three interesting facts about the use of RIASOL for psoriasis:

One, **RIASOL by actual clinical tests proved effective in 76% of cases in a controlled group.**

Two, **RIASOL cleared or greatly improved the skin patches in an average period of eight weeks in this test.**

Three, **RIASOL reaches and helps alter the lesions of psoriasis located in the deeper epidermal layers.**

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

Ethically promoted RIASOL is supplied in 4 and 8 fld. oz. bottles at pharmacies or direct.

MAIL COUPON TODAY—
TEST RIASOL YOURSELF

Dept. ME-9-52

SHIELD LABORATORIES
12850 Mansfield Ave.,
Detroit 27, Mich.

Please send me professional literature and generous clinical package of RIASOL.

..... M.D.

Street .....

City .....

Zone .... State .....

Druggist .....

Address .....

RIASOL FOR PSORIASIS

2. Its membership recruiti drives employed unethical adve ing.

3. Payment arrangements b tween the co-op and its medi staff were unsatisfactory.

4. The hospital's monthly bu tin was being used for propaga purposes and improper solicitati

To meet these objections, the co-op has now agreed:

1. To let its members choose th physicians either from the co-o medical staff or from outside it; the latter event, the patient w have to pay the doctor's fee hi self.

2. To conduct no more membe ship solicitation campaigns.

3. To pay its medical staff least 50 per cent of the rece from membership dues and all the receipts from physicians' fe paid by non-members," minus "t legitimate expense of operating t medical services."

4. To avoid using its bulletin f purposes of propaganda or solic tion."

One Way to Remove St From Hospital Bills?

Translate hospital bills into working man's language and won't hear so many gripes, George Wood, administrator of N alta Hospital, Oakland, Calif. prove his point, he recounts the lowing incident:

A plumber stormed into Pe Hospital, waving a bill coverin wife's hospitalization for an e

in Others' Words

A Young Physician:

"Although I have just completed a new office and cash assets are low, I believe that this contribution is a 'must' for every doctor of medicine, and herewith enclose my 1951 check in the amount of one hundred dollars."

DO YOUR PART TODAY

If you have missed doing your part—why not send your contribution today. All gifts can be earmarked for any one of the approved medical schools—and the money is income-tax deductible. Send your check now.

American Medical Education Foundation

533 North Dearborn Street, Chicago 10, Illinois

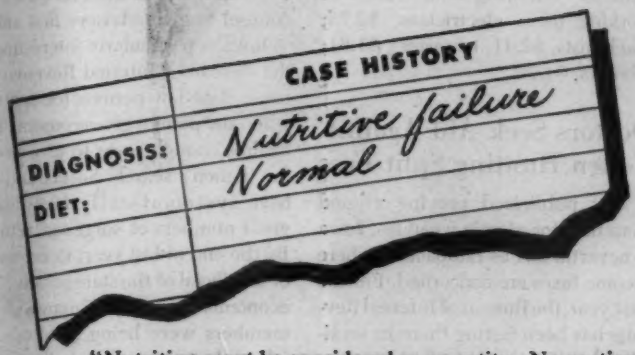
gency appendectomy. "This bill i terrible, and I'm not going to pa it!" he shouted. "How can you ex pect a working man like me to pa $128 for three days of care? Wha we need is hospitals run by the Government."

When asked whether the hospi tal services had been satisfactory, he could find no cause for com plaint. "Well, then, what would you charge for three continuous days and nights of plumbing services?" Wood asked. The plumber's an swer: $22 for each of three eight-hour days, plus double time of $3 for each of the three sixteen-hour night shifts, making a total of $330.

Wood then pointed out that i took the equivalent of five-sixths o one hospital employe's time, work ing around the clock, to care for the plumber's wife. What's more, the hospital had provided other things such as food, medication, and sur gical equipment, plus techniques and skills at least as specialized as those used in plumbing.

The comparison hit home, and the plumber amicably agreed to pay the bill. "For the first time," he said "someone has taken the time to ex plain hospital charges to me, in lan guage I can understand."

As ammunition for future in cidents like this, says Wood, the hospital has worked up a compari son of area hospital rates with thos charged by local trades. By any sta standard, it appears, the hospit charges seem modest. Hourly co of hospitalization, including all ser ices, averages $1.11, as compar



"Nutrition must be considered as an entity. No particular constituent is more important than another. Each nutrient should be present in its optimum quantity."[1] "If one nutrient is not adequate, this may also interfere with the functioning of other nutrients in the body."[2]

Vitamins, Minerals and Trace Elements each play a specific important role in nutrition.

1. Simonnet, H.: Nutrition in Pregnancy, Canad. M. A. J., 58:536, (June) 1948, p. 60.
2. The Nutrition of Industrial Workers; Second Report of the Committee on Nutrition of Industrial Workers, Food and Nutrition Board, National Research Council. Reprint and Circular Series No. 123. (Washington, D. C.: National Research Council), Sept., 1945, p. 13.

10 Vitamins
11 Minerals and
Trace Elements
All in One Capsule

Vi terra

Vitamin A	5,000 U.S.P. Units
Vitamin D	500 U.S.P. Units
Vitamin B_{12}	1 mcg.
Thiamine Hydrochloride	3 mg.
Riboflavin	3 mg.
Pyridoxine Hydrochloride	0.5 mg.
Niacinamide	25 mg.
Ascorbic Acid	50 mg.
Calcium Pantothenate	5 mg.
Mixed Tocopherols (Type IV)	5 mg.
Calcium	213 mg.
Cobalt	0.1 mg.
Copper	1 mg.
Iodine	0.15 mg.
Iron	10 mg.
Manganese	1 mg.
Magnesium	6 mg.
Molybdenum	0.2 mg.
Phosphorus	165 mg.
Potassium	5 mg.
Zinc	1.2 mg.

J. B. ROERIG AND COMPANY
536 LAKE SHORE DR., CHICAGO 11, ILLINOIS

with the following hourly rates of working men: electricians, $2.75; machinists, $2.41; teamsters, $1.81; laborers, $1.70.

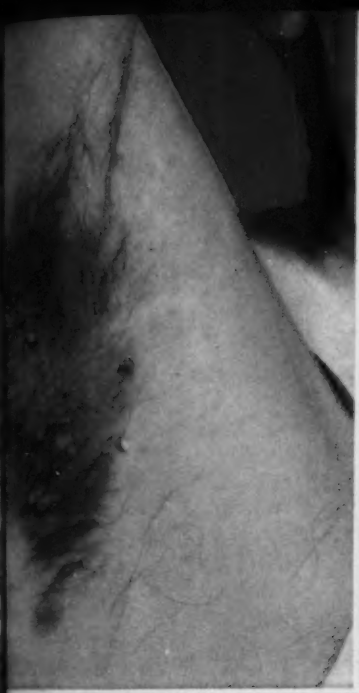
Doctors Seek Aid Against T-Men Hunting Split Fees

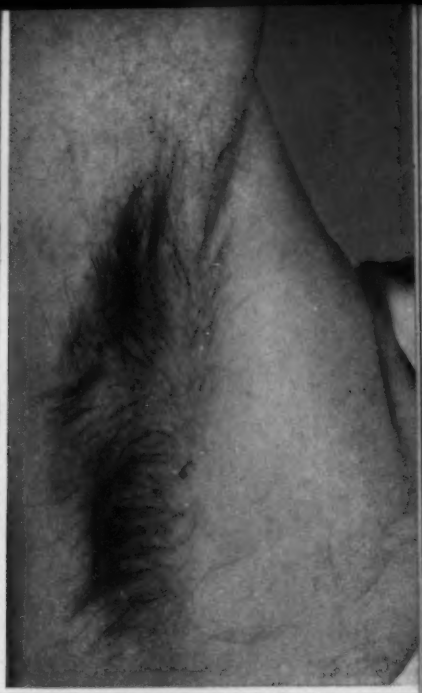
A less publicized proving ground than that for atomic weapons, Iowa is nevertheless as radioactive where income taxes are concerned. For the past year, the Bureau of Internal Revenue has been testing there its semi-official policy that split fees are non-deductible on doctors' tax returns.

Latest test report: There's a lull at present, but the T-men's policy has strewn the state with tax actions. So many physicians have become audit casualties that the state medical society has drafted its own legal counsel to give advisory first aid.

Iowa is particularly interesting to the Bureau of Internal Revenue because state law permits fee splitting when the patient gives consent. This assures enough cases to give zest to the T-men's search. So tax auditors have systematically investigated great numbers of surgeons' returns. By the end of last year, in the words of an official of the state society, "the economic lives of so many of our members were being affected . . . [that] the trustees felt . . . the society should take some position in the dispute." It was then that the society's legal counsel got his summons to action.

"I believe every county in the state has had someone involved in





April 5, 1951. Pruritic seborrheic dermatitis of 6 years' standing. Treatment over the years with various medicaments had failed.

May 24, 1951. After just 7 weeks with 'Pragmatar'. (After one day, itching stopped. After 1 week there was marked clinical improvement.)

seborrheic dermatitis

PRAGMATAR*

ghly effective in an unusually wide range of common skin disorders

'Pragmatar' is generally recognized as the most effective preparation available for seborrheic dermatoses, and for many other common skin disorders. Among them: common scalp disorders and dandruff; eczematous eruptions; fungous infections, including "athlete's foot"; pruritus, etc.

Formula: Cetyl alcohol-coal tar distillate, 4%; near-colloidal sulfur, 3%; salicylic acid, 3%—incorporated in a special washable base.

With Kline & French Laboratories, Phila. *T.M. Reg. U.S. Pat. Off.

This is the first of a series of Norman Rockwell portraits depicting patients typical of those you see in your everyday practi

of the distress you can see

This typical patient may have a multitude of somatic complaints—some real; some imagined. But she probably will fail to complain of her mental and emotional distress—*distress you can see*. This is the distress that either causes—or to some degree complicates—virtually every condition you are called upon to manage.

You will find 'Dexamyl' of unique value in treating the mental and emotional aspects of your patients' somatic complaints. 'Dexamyl' is a balanced combination of *two* mood-ameliorating components:

1. Dexedrine* Sulfate—the antidepressant of choice—to lift the patient's mood and provide a sense of well-being.
2. Amobarbital (Lilly)—the sedative that elevates mood—to relieve nervousness, anxiety, and inner tension.

Dexamyl's two mood-ameliorating components work synergistically to provide a "normalizing" effect—free of the dulling effect of barbiturates; free of the excitation caused by stimulants.

DEXAMYL* tablets and elixir

Each 'Dexamyl' *Tablet* contains 'Dexedrine' Sulfate (dextro-amphetamine sulfate, S.K.F.), 5 mg.; and Amobarbital, ½ gr. Each 5 cc. teaspoonful of 'Dexamyl' *Elixir* is the dosage equivalent of one 'Dexamyl' Tablet.

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.

this problem," says the counsel, I. W. Myers. Appeals for his aid have come, he claims, from thirty different Iowa communities.

After considerable research in tax law, Myers has set up a clearing house of information that hands out legal ammunition to embattled physicians in any sector of the state. He confers with doctors and their attorneys on individual problems, and he represents physicians at parleys with tax auditors.

After a U.S. Supreme Court decision some months ago pulled the checkrein on Bureau of Internal Revenue split-fee policy [See "Supreme Court Quashes Kickback Case," May MEDICAL ECONOMICS], Myers organized an all-day tax conference for Iowa doctors and attorneys. The conference worked out a program of legal research that was expected to justify completely the doctors' handling of split fees on their tax returns. But soon afterward the American College of Surgeons announced its intention of eradicating fee splitting, with B.I.R. aid. "That was not exactly helpful," Myers comments.

He still hopes, however, that conferences with tax auditors will extricate the numerous Iowa doctors from threatened tax penalties. "If . . . not, I feel rather confident that these cases can be won in court."

So far, the T-men have been devoting their attention mainly to surgeons' tax returns. But Myers suspects that they may extend their search for split fees into other situations. "It seems to me," he warns, referring to the bureau's policy of disallowing a divided fee, that the "ruling could prevail just as well in a clinic or a partnership."

Patients Show Impatience With Waiting Room Waits

That deceptive quiet in your reception room may mask a mounting exasperation. This warning comes from a California physician who was assigned the task of interviewing friends, patients, and the general public for the Sacramento County Medical Society, in a one-man public relations survey.

Here are sample snarls he heard on the subject of being kept waiting to see the doctor:

"You doctors are just trying to fool us into thinking you're important. Bunk! You're just inefficient."

"What do you medics think we are—patients, or just a bunch of sheep to be herded around for the slaughter?"

"When we're kept waiting longer than necessary, I think we should refuse to pay the full amount of the bill."

Commenting on the doctor's findings, the county medical society bulletin points out that these are not isolated complaints "from a few . . . chronic complainers but . . . typical of a general feeling about long waiting periods." Such reactions, it adds, point up the necessity for every physician "to correct appointment-timing defects if they exist in his of-

Knox Gelatine... useful protein supplement for the growing child

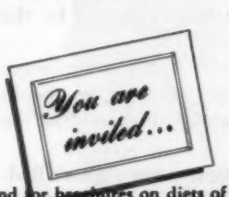
PROTEIN

For Body Growth

Protein not only helps feed the machine of the growing child but is itself the machinery. An abundance of protein both for body growth as well as for blood, enzyme and hormone synthesis is a primary requirement in childhood. While carbohydrate and fat may be stored in the organism, protein must be taken in daily to maintain the structural mass of tissue.

Abundant Energy

The daily diet must contain the so-called essential amino acids as first shown by Osborne and Mendel[1] and more precisely defined by Rose.[2] Once the essential amino acids are furnished, the remaining ones may be taken in abundance from other protein sources to insure full growth and create abundant energy.



to send for brochures on diets of Diabetes, Colitis, Peptic Ulcer . . . Low Salt, Reducing, Liquid and Soft Diets. KNOX GELATINE, JOHNSTOWN, N. Y. DEPT. ME

Easy to Digest

Knox Gelatine is an excellent protein supplement, easy to digest and administer and non-allergenic. It may be prepared in a variety of ways from Knox Gelatine Dishes to delicious salads and desserts.

High Dynamic Action

Gelatine in the form of gelatinized milk has been found a valuable protein supplement helpful in allergies, celiac disease, colic and to increase the digestibility of the milk formula.[3] Its high specific dynamic action which spares essential amino acids and furnishes amino acids for the continuous dynamic exchange of nitrogen in the tissue[4] helps the child to maintain the normal body heat. Furthermore, it contains an abundance of important glycine and proline necessary for hemoglobin formation.

1 Osborne, T.B. and Mendel, L.B., J. Biol. Chem. 17:325, 1914.
2 Rose, W.C., Physiol. Rev. 18:109, 1938.
3 Wolpe, Leon Z. and Silvermone, Paul C., J. Pediat. 21:6, 1942.
4 Lusk, G., J. Nutrition 3:519, 1931. Borsook, H., Biol. Rev. 11:147, 1936.
5 Schoenheimer, R., Razner, S., and Rittenberg, D., J. Biol. Chem., 127:333, 1939 and 130:703, 1939.

Available at grocery stores in 4-envelope family size and 32-envelope economy size packages.

KNOX GELATINE U. S. P.

All Protein No Sugar

fice." How? Here's the bulletin's formula:

1. Train your office employes to pay closer attention to your time habits.

2. Guide them in estimating the length of time for various treatments.

3. Insist on their keeping track of your time and advising you accordingly.

For Tax Purposes, What *Is* Entertainment?

Now that the Bureau of Internal Revenue has formally confirmed the deductibility of *doctors'* entertainment costs for income tax purposes [See "You *Can* Deduct for Entertainment," August MEDICAL ECONOMICS], an obvious question arises:

What *is* a legitimate entertainment cost?

In an attempt to dispel some of the confusion, Dr. J. W. Thompson, president of the Missouri State Medical Association, recently asked the Bureau of Internal Revenue for rulings on the deductibility of three types of items. The bureau's answer, in effect: "It all depends."

Here are Dr. Thompson's questions, along with the answers furnished by the bureau's Commissioner John B. Dunlap:

Q. Are physicians allowed to deduct contributions to funds raised for the social activities of student hospital nurses? These contributions are physicians' expressions of appreciation of service rendered by these

J. W. Thompson
Three questions for T-men

. . . nurses to physicians and their patients.

A. Whether or not [such] contributions . . . are deductible as a business expense under section 23 (a) of the [Internal Revenue] Code depends upon whether, in the practice of his profession, a doctor is expected by custom to make such payments and whether the amounts thereof are commensurate with the services rendered for which they represent compensation.

Q. Are physicians allowed to deduct contributions made to hospital interne funds?

A. [Same as above.]

Q. Are physicians allowed to deduct expenses of Christmas or other anniversary presents sent to patients or to other physicians? And are physicians allowed to deduct the cost of floral offerings and kindred items

sent to patients or to other M.D.'s on joyful or sorrowful occasions?

A. Ordinarily, gifts to individuals constitute personal expenses, the deduction of which is prohibited by section 24 (a) (1) of the Code. Whether or not amounts expended by a doctor for gifts and floral offerings to his patients, other doctors, and/or members of their families and for entertaining such persons constitute ordinary and necessary business expenses for Federal income tax purposes must necessarily depend upon the facts in each particular case. Since a large personal element is generally present in such matters, substantial evidence is a prerequisite to the allowance of such amounts as deductible business expenses.

If it can be shown that a business benefit commensurate with the amount of the payments results from such gifts and entertainment, the amount thereof might constitute an allowable deduction as a business expense.

D.P.'s Help Lick Rural Doctor Shortage

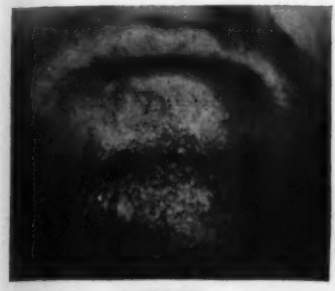
In their anxiety to attract physicians into rural areas, community leaders have dangled a variety of lures. But some just can't seem to hook a doctor, no matter what the bait.

For such areas, South Dakotans say, D.P. physicians may be the answer. In that state, foreign doctors are temporarily licensed to practice for four years in "emergency" areas. To get a temporary

A New and Improved Therapy for DERMATITIS in Hairy Areas

Case: **40 year old male, laborer.**

Diagnosis: **SYCOSIS VULGARIS (Barber's Itch)**



BEFORE

Marked infiltrated erythema, pustulation, crusting and fissuring in spite of prior applications of various ointments, ultra-violet, penicillin, and x-ray.

AFTER

Condition almost completely cleared after eight weeks of treatment with SUPERTAH-5 WITH SULFUR AND SALICYLIC ACID. No infiltration, crusting or fissuring evident.

Proven Therapeutic Efficacy of Coal Tar . . .

. . . contains the equivalent of 5% crude coal tar (as in Regular SUPERTAH-5), with 4% sulfur and 3% salicylic acid — free from coal tar's color, odor, irritating and staining.

In Convenient Non-Greasy Base . . .

. . . massages into the skin and scalp without creating a gummy, greasy condition. Will not stain.

SUPERTAH-5 WITH

Ethically distributed in 1½-oz. jars.

Regular SUPERTAH, the white, non-staining, non-irritating coal tar ointment for Eczema and Allied Skin Diseases is milled in 5% and 10% tar strengths. SUPERTAH-10 for the early stages of therapy and SUPERTAH-5 for use when weeping and crusting have begun to subside.

Ethically distributed in 2-oz. tubes and 2-oz. jars with removable labels.

TAILBY-NASON COMPANY
Kendall Sq. Sta., Boston 42, Mass.

"Sphinx" Reliable Pharmaceuticals Since 1905

Not three...but Four

Four factors are now recognized in the treatment of peptic ulcer...

1. ***Neutralizing hyperacidity.*** KOLANTYL includes a superior antacid combination (magnesium oxide and aluminum hydroxide, also a specific antipeptic) for two-way, balanced antacid activity.

2. ***Protecting the crater.*** KOLANTYL includes a superior demulcent (methylcellulose, a synthetic mucin) which forms a protective coating over the ulcerated mucosa.

3. ***Blocking spasm.*** KOLANTYL includes a superior antispasmodic (Bentyl) which provides direct smooth-muscle and parasympathetic-depressant qualities . . . without "belladonna backfire."

And only KOLANTYL includes the important 4th factor

4. ***Inactivation of lysozyme*** . . . with a proven antilysozyme, *sodium lauryl sulfate*. Laboratory research[1,2,3] and clinical results[4] indicate that the enzyme lysozyme is one of the etiologic agents of peptic ulcer. By inhibiting or inactivating lysozyme, KOLANTYL—and *only* KOLANTYL—provides the important 4th factor toward more complete control of peptic ulcer.

DOSAGE: Two tablets every three hours as needed for relief. Mildly minted, Kolantyl tablets may be chewed or swallowed with ease.

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1. Meyer, K. et al. Am. J. Med. 5:482,1948. 2. Wang, K. J. and Grossman, M. I. Am. J. Phys. 155:676,1949. 3. Grace, W. J. Am. J. Med. Sc. 217:84,194
4. Hufford, A. R. Rev. of Gastroenterology, 18:588, 1951.

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license, the D.P. must first (1) spend a year as interne in a South Dakota hospital of fifty beds or more; (2) be approved by that hospital's staff; (3) pass a basic science test; and (4) pass the state medical examining board quiz.

The incentive for the D.P. doctor is this: After his four-year stint, he gets a regular license and can practice anywhere in the state, provided his record has been approved by the state's medical examiners.

The D.P. program has been in operation since 1949, when the South Dakota State Medical Association got the state legislature to pass a bill legalizing it. According to John C. Foster, executive secretary of the association, the experiment has been a whopping success. Some typical examples:

¶ Lake Norden (pop. 343), in the east central part of the state, had been without a physician for ten years, until the arrival of Dr. Romans Auskaps of Latvia, eighteen months ago. Dr. Auskaps reports that he has plenty of work—so much, in fact, that he's had little chance to sample the area's fishing, boating, swimming, and hunting facilities.

¶ Eagle Butte (pop. 247), in the west central part of the state, sponsored Dr. Roman Hura while he interned in St. Mary's Hospital in Pierre. The townspeople then helped him set up his practice, which "has been improving steadily, although slowly." He's been able to buy a car, the lack of which handicapped him at first.

¶ Isabel (pop. 342), north of Eagle Butte, sponsored a Latvian doctor, Oskars Ziedaks, through his interneship in Sioux Valley Hospital in Sioux Falls. He's been in Isabel more than a year now, and is highly thought of by the community.

¶ Onida (pop. 523), in the central part of the state, landed Dr. Alfred Rimsa, promptly put up a twenty-bed hospital and clinic for him. An osteopath had previously been the town's sole practitioner.

What will happen after the D.P. physicians get their regular licenses and are free to move? That's "anybody's guess," says Executive Secretary Foster, "but for the moment they are filling a definite need."

Who Owns a New Fixture —You or the Landlord?

If you install fixtures in a rented office, have you the legal right to take them with you when you move? Does the law give enough protection to justify your investing in such fixtures?

Two factors govern the answers to these questions:

1. The ease with which the fixtures can be removed; and
2. The terms of your lease.

This is evident from a summary of fixture-ownership facts for tenants of rented offices, recently published in Office Management and Equipment magazine. If an installation isn't affixed, it isn't a fixture, the summary shows, and so may be removed at will. But fastened-down

equipment does raise questions o ownership.

Take electric fixtures and air co ditioning units, for instance: If the can be removed without damage t the real estate, or if the tenant re pairs any resulting damage, the may still be his to haul away. I special cases, courts have ruled tha tenants may remove such firmly at tached fittings as mirrors screwe to the wall, machinery screwed t the floor, and even a steam-heatin plant.

The report goes so far as to cha lenge even the assumption that "par titions fastened to the walls belon to the owner of the building." I these can be removed without dam age, and if the lease permits, they a the property of the purchaser, it says. But it repeats that the tenan is usually obligated to repair dam age and—in some cases—to restor original conditions.

Of course, even though you've paid for a fixture, you can't *always* legally take it with you. For exam ple, you may not take it:

¶ If it replaces a previous fixture now thrown away, without the land lord's consent. Legally, this is a sub stitution rather than the installation of a new fixture. Moral: Get the landlord's permission to remove an old fixture, and save it to replace yours as you leave.

¶ If removal will cause "substan tial damage" to the real estate.

¶ If you fail to claim your prop erty promptly at the end of your tenancy or at the expiration of the lease. Courts regard this as abandon-

ment. If you accept a new lease that doesn't list the fixture as yours, you may also forfeit ownership.

Your lease is crucial in protecting ownership of improvements, the report points out; so before installing a fixture, get either the landlord's signature to an agreement or a new clause in your lease specifying who is to pay for the item, who is to own it at the end of your tenancy, and who is to bear the expense of restoring original conditions.

More State Societies Now Sending Out Field Men

Doctors in more and more states are now getting active help from their state medical societies, through field representatives. Each of eight state associations now has at least one full-time field man. North Carolina has two; California has three; and New York has two full-time and two part-time.

Twenty-one other associations arrange for staff members to travel part of the time as field men. Thus more than half the state societies are offering this service to doctors, according to a survey by the A.M.A. Department of Public Relations.

In the course of his rounds, the field man performs chores of a variety to impress even the original Man Friday. In one community, he may help set up an emergency-call plan; in another, he may organize a training course for doctors' secretaries. When legislation is pending, he stalks legislators to present the medical point of view. He makes

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investigations for baffled grievance committees. In helping to launch P.R. programs, he calls on editors and radio men, service clubs and civic groups.

In connection with such activities, the full-time field man may travel up to 1,500 miles a month. This usually puts him in touch with from five to fifteen component societies. Indiana's representative breezes around to as many as twenty-five in thirty days; and the four-man New York staff may visit a total of sixty.

Warning: Your Tongue Can Wag You Into Court

What's the easiest and most effective way of steering clear of malpractice suits? One obvious answer: Guard your tongue.

If you have any doubts about this, consider the words of E. C. Fisher, of the Aetna Casualty and Surety Company, who estimates that "at least 80 to 85 per cent of the claims and suits that are brought against doctors are absolutely without just grounds."

If there are no just grounds, how does the doctor get into legal trouble in the first place? You guessed it —he talks himself into it.

Here's some advice for muzzling that loose tongue, and thereby cutting unfounded claims, as outlined by Fisher in the North Carolina Medical Journal:

¶ "Treat every patient, especially a new one, as a potential claimant. It often happens that the patient over whom you have worked the hardest and with whom you secured the best results will have the least appreciation . . . The charity patient is just as prone to bring suit and has just as strong a chance of making a recovery in dollars and cents as the patient who is able and willing to pay his bill.

¶ "Avoid misleading remarks." While undergoing a simple dilatation and curettage, a patient's blood pressure suddenly dropped and she died, through no one's fault. A few days later, her husband asked the surgeon what caused the death. The surgeon replied: "It was one of those medical accidents." To the husband the word "accident" meant that someone had been negligent. He sued.

¶ Talk to the patient "in as simple terms as possible. Many a claim has been precipitated by too detailed a discussion of symptoms and findings in complicated language."

¶ Don't make "damaging admissions and commitments. If a patient comes back to complain about something you have done, never make any admission or commitments even if his complaint is, in your opinion, somewhat justified."

Fisher advises taking the same tack with a lawyer investigating a patient's claim. If he sends you a letter, turn it over to your insurance company instead of answering it. Or, if the attorney calls in person, "refuse to discuss the matter with him, stating firmly but politely that he is engaged in the practice of one

profession and you in another, and that you would rather have your representative discuss the matter than do it yourself."

Doctors' Clash With Polio Foundation Ends Happily

Financial success is attained by lay health agencies in proportion to their emotional appeal to the public. Witness the many millions collected by the crippled-child symbol of the National Foundation for Infantile Paralysis, since its modest start twenty years ago.

But the ultimate usefulness of such an agency in controlling the disease it crusades against is entirely dependent on the medical profession. Despite this, organized medicine is rarely consulted about the policies of these agencies and is even more rarely credited for its contribution to their success.

This, according to David R. Murphey Jr., president of the Florida Medical Association, has been the pattern of relationship between Florida doctors and the National Foundation for Infantile Paralysis. But, says he, there's a promise of better things ahead. Friction between the foundation and the medical association may soon be ended by a mutually acceptable code of cooperation.

"This agreement will . . . benefit . . . both organizations," comments Dr. Murphey. "For the first time in its history, the medical profession of Florida is in a position to supervise officially the care of victims of poliomyelitis in the state."

David R. Murphey Jr.
What policy on polio?

In a report to the medical association's board of governors, he points out that a basic reason for the clash between doctors and the foundation is that "this organization has definitely entered the practice of medicine."

Specifically, he charges, the foundation has:

¶ "Interfered with free choice of physician by the patient and his family."

¶ Tended "to pauperize every victim of [polio], regardless of his financial status."

¶ Prolonged treatment in some cases "into the static stage of the disease."

In addition, he adds, the foundation has posed as St. George fighting the polio dragon alone, without

acknowledging that "victims of this dreaded disease have been cared for by individual members of our profession, often without compensation and never with any [public] recognition."

As the result of a recent series of conferences on all such problems, however, future cooperation seems probable.

The agreed-upon code, Murphey feels, will assure future rapport. It includes the following recommendations:

1. Each state and county chapter of the foundation will work with its own medical advisory committee, appointed by the state medical association.

2. "The patient must always have free choice of physician."

3. "The county chapters of the . . . foundation are to consider carefully all requests for financial assistance, and make an earnest effort to educate the family . . . to participate in the expense of medical care and treatment, to the extent of its ability."

4. The foundation is to "give public recognition, in a suitable manner, to the indispensable role played by the medical profession in carrying on [its] medical care program."

Accuse Medical Schools Of Still Barring Jews

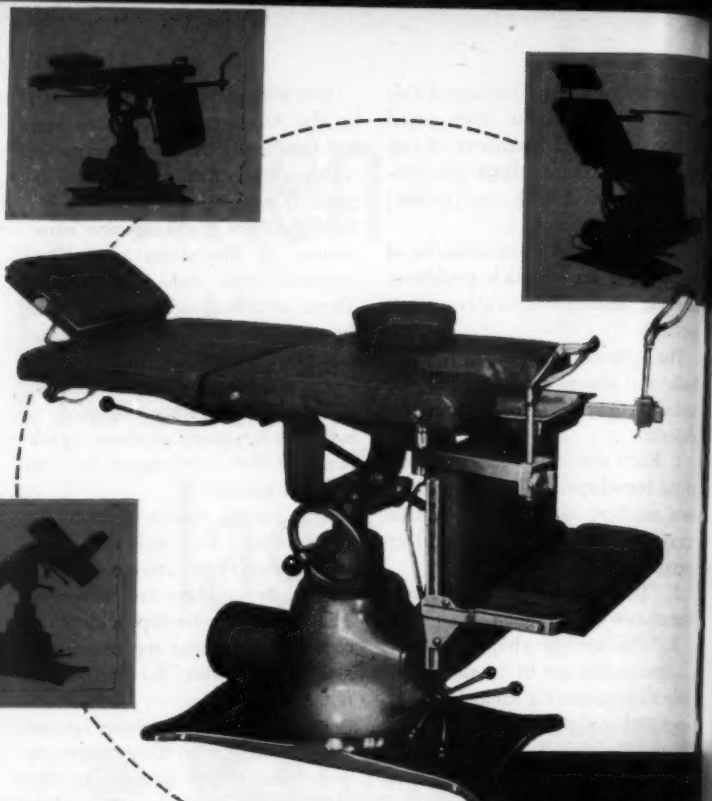
Although New York has a law against it, most of the state's nine medical schools are apparently still discriminating against qualified Jewish applicants.

This charge was leveled recently by the American Jewish Congress and the New York State Committee on Equality in Education. These organizations made a joint study—their third—of the admission experiences of fifty-seven premedical students with state scholarships. These students included forty-one Jews and sixteen non-Jews. Scholarship winners were deliberately selected for the survey because, as top students, they were assumed to have the necessary academic qualifications for acceptance by any medical school.

The survey reveals that Jewish students were only half as successful as non-Jewish students in getting their applications accepted. The Jewish scholarship holders had only a 35.9 per cent acceptance rate as compared with 76.1 per cent for non-Jews.

Not that Jewish students ran into much trouble with their written applications, which cannot, in New York, legally pose questions about race or religion. Rejections came for the most part after personal interviews. These, claims the survey report, are "being used—either consciously or unconsciously—as a technique for screening 'undesirable Jewish applicants.' "

Of the state's nine medical schools, Cornell University Medical College was the worst offender, according to the investigators. Cornell's record: two out of thirty Jewish applicants accepted as against two out of two non-Jewish appli-



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cants accepted. New York Medical College ran second; it admitted only one Jewish student out of thirteen who applied. In contrast, Long Island University Medical School acted favorably on twenty-six out of twenty-nine Jews' applications.

Heard the One About the Psychiatrist Who . . .?

Almost everyone jokes about psychiatrists, and it's "all to the good," according to Carl Binger, associate professor of clinical psychiatry at Cornell University Medical College.

The gist of a lot of these old chestnuts, says Psychiatrist Binger, is that "psychiatrists are just as crazy as anyone else—perhaps more so." He gives an example:

Psychiatrist to patient: "I guess I could cure you of your depression, if everything didn't seem so damn futile to me."

A second category of jokes, notes Binger, "presents the psychiatrist as no better than he should be":

A couple of psychiatrists have a brief love affair. A year later, learning that she has had a baby, he offers marriage. She declines, saying, "Father thinks it's better to have one bastard in the family than two psychiatrists."

Such "friendly, affectionate, mildly derogatory comments," says Binger, "reflect a better understanding of psychiatry and a better relationship with psychiatrists. They clear the air and leave a healthy aroma of ozone far pleasanter to the nostrils than the sultry, cynical, and murky atmosphere which envelops us from some quarters."

Carl Binger
The joke's on us

His conclusion: "Much is expected from psychiatry and psychiatrists in the face of existing confusion, chaos, and tragedy. It is all too obvious that their knowledge is insufficient and their powers limited. At best they can hope to make their influence felt by cooperation with other experts."

Calls for Weeding Out of 'Medical Parasites'

Ever met a medical parasite? He's the doctor "who sits back doing nothing for medicine but milking it for all it is worth," according to an editorial in the Norfolk (Mass.) Medical News.

"He practices primarily for his

own personal gain," according to the journal, though taking full advantage of favorable conditions that his less self-centered colleagues must work to maintain. And he's easy to recognize, since he:

¶ Joins the medical society "only because he has to in order to enjoy its benefits";

¶ Skips all meetings;

¶ Argues against paying dues;

¶ Refuses to support community medical projects with his time or money;

¶ Criticizes his colleagues' efforts to combat socialized medicine;

¶ Bases his criticism on hearsay only.

"There are too many parasites in our societies," says the journal; and it recommends a research project to consider ways of exterminating this parasitical attitude, as well as other problems of medical organizations. "We *might*, thereby, be able to find some basic formula for creating a more active interest, on the part of many more members, in the affairs of our medical societies."

Good News on Tax Relief For Doctor-Authors

Have you been reluctant to write a book because the tax collector would hog the proceeds? If so, you might now consider taking up your pen. Apart from the professional satisfaction you'll get, your share of the profits of authorship can easily exceed 75 per cent—thanks to a recent ruling of the Tax Court.

According to the Court's decision,

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Bacteriologists and other authorities agree
1) That boiling merely sanitizes, or makes objects sanitary.
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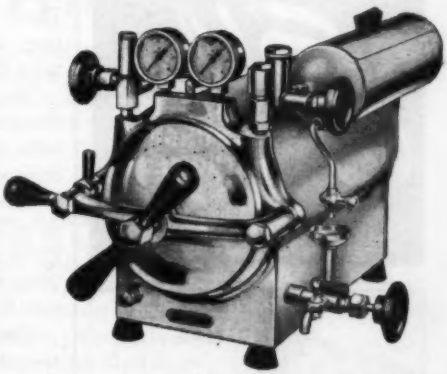

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the proceeds from an M.D.'s manuscript may, under certain fairly common circumstances, be treated as a long-term capital gain. As a result, a Baltimore gynecologist has saved $9,700 in taxes on royalties of $13,700.

Back in 1941, a publisher asked Dr. Richard Te Linde to write a book on his specialty. An agreement was signed, under which Te Linde gave the publisher sole rights to the book and agreed to deliver the manuscript by a certain date.

The book was substantially completed in January, 1945, but it wasn't delivered to the publisher until the following August. This delay is what brought the Baltimore physician his big tax saving.

On his tax return, he classed the payments he received from the publisher as long-term capital gains. These are subject to half the ordinary income rates, but never to more than 25 per cent.

The Bureau of Internal Revenue disagreed. In its view, the payments were ordinary income; and if not ordinary income, they were certainly short-term capital gains, taxable as ordinary income. So the Bureau maintained that the M.D. owed another $9,700. But the Tax Court has now thrown out the Bureau's case.

The Court first settled the question of capital gain versus ordinary income: The fact that the publisher received all rights made the transaction the sale of a capital asset. Then it turned to the really crucial problem: Was the capital gain long-term or short-term? In other words, had

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the doctor held his "capital asset" for more, or less, than six months?

The Court's answer: Since the book first came into being when the manuscript was finished—in or before January, 1945—and wasn't delivered until seven months later, Dr. Te Linde was entitled to use the lower, long-term rate.

Will High Fees Undermine Catastrophe Insurance?

Catastrophic coverage can succeed only if patients keep their medical costs within reasonable limits. An indiscriminate ladling out of more money to more people for ever higher bills could result in "economic catastrophe" rather than catastrophe coverage. This warning comes from A.M. Wilson, spokesman for the Liberty Mutual Insurance Company, which pioneered this type of insurance in the commercial field.

He believes that catastrophic insurance underwriters should take a broad view of possible expenses to be covered, but that they must closely scrutinize actual amounts. What may be considered insurable medical expenses? Practically anything the doctor orders, says Wilson: hospital costs, nurses' fees, physicians' fees, drugs, dressings, appliances, therapeutic treatments, supplies, even travel expenses in some cases.

But each item, he specifies, must pass two tests:

1. Is the service necessary?
2. Is the charge reasonable?

The line between necessity and

Eight decades ago 70% of all gainful workers in the U. S. A. toiled in agriculture. Today farms and factories, put together, account for less than 40%.

The rest serve chiefly in distribution, which includes the physical movement of products to buyers, and all forms of selling, advertising and sales promotion.

Without sales a business fails and jobs vanish. No matter how good a product may be, it must be sold in competition with other goods. A salesman sometimes finds his products not truly competitive. He then exercises tremendous pressures on his employer for better products, lower prices, or both. Thus, competitive selling greatly influences the progress of American prosperity.

Countries where selling is inefficient, restricted or eliminated generate far less wealth, happiness and security.

Competition, especially competitive selling, is a great American Freedom. Let us preserve it to assure Progress For All Our People.

THIS REPORT ON PROGRESS-FOR-PEOPLE is published by this magazine in cooperation with National Business Publications, Inc., as a public service.

THE COMPETITIVE SYSTEM DELIVERS THE MOST TO THE GREATEST NUMBER OF PEOPLE

luxury is not clear-cut, he finds, with costs of a hospital room ranging from $10 to $100 a day, for example. And he has known a patient to consider three hospital rooms "necessary": one for herself, one for her husband, and another for the flowers she received.

He defines "reasonable" as "in line with charges in the area made by good hospitals, physicians, and nurses under similar circumstances." Applying that definition, however, keeps claim investigators hopping, he admits.

One typical problem, adds Wilson, is to determine who shall be allowed to charge a premium fee as a specialist. What about the "medicine men who act like specialists, talk like specialists, but have never qualified themselves by study and training as specialists"? These are particularly numerous in the field of mental health, he observes—so much so that his company once considered rejecting claims for psychoanalysis charges except when the physician had been certified by the specialty board. But this restriction, the company found, would exclude many who are competent men. To identify legitimate specialists,, he says they now rely upon "good medical evidence to defeat bad medical practice."

Any definition of "reasonable" cost also collides head-on with the sliding-scale concept of basing a bill on a patient's ability to pay, Wilson points out. He cites the case of a well-to-do clinic patient billed for $4,900 "for medical attention

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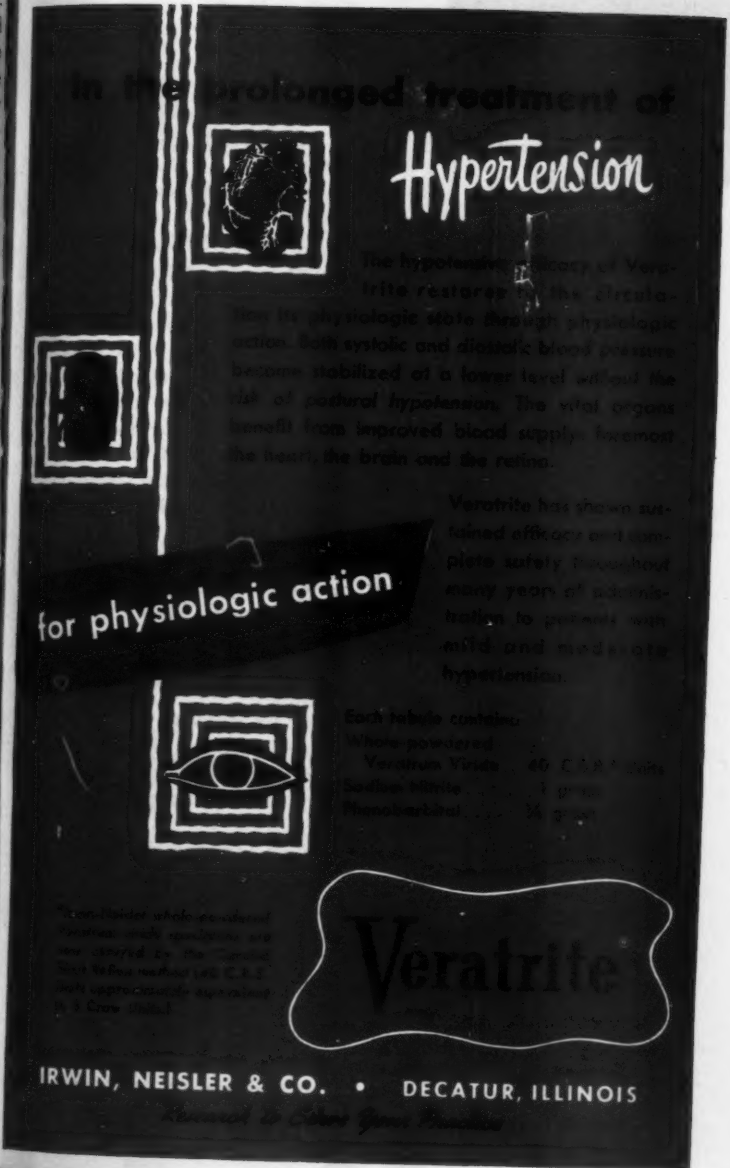
which, under ordinary conditions, could have been obtained at any good hospital for a maximum of $600." That's *not* a reasonable charge, he maintains; it's just a way of "forcing a wealthy man to make a donation . . . to support treatment for those who cannot pay." And he laments that "there is no recourse through the medical societies against such action."

Thus, the responsibility for the success or failure of catastrophic coverage "rests directly with the people," who must, says Wilson, "have the courage to ask before the fact what the charges will be."

Patients who feel abashed about protesting exorbitant charges simply invite more of the same, he adds: "For example, we were presented with [a claim] for $750 . . . for a normal delivery. We produced twenty-two other cases in the same area, of people in the same income bracket who had specialist fees for normal delivery, none of which exceeded $250. [Yet] the insured took the position that he paid this same physician $750 for the first child, $750 for the second, and expected to pay the same for the third."

Wilson predicts that if patients would use as much common sense about incurring medical costs as about their other expenses, the fee-gouging minority in the medical profession would lose their practice to the majority who make reasonable charges. Then, he concludes, there would be "great hope for medical catastrophe insurance."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Memo from the Publisher

● Since MEDICAL ECONOMICS is basically a "fact" magazine, our editors naturally take great pains to get their facts right. But they take even greater pains with their *opinions*—in particular, with the opinions expressed on our Editorial page.

The editors begin every month with a pooling of ideas—a search for the most timely subject, the most provocative message. Promising ideas are batted back and forth across the conference table, then developed further through interviews with outside authorities.

Thus, almost everyone on the staff plus a good many people not on the staff contribute of their thinking to these editorials at one stage or another.

One of our main concerns in expressing editorial opinion is to be forceful yet fair. Three brief excerpts from past editorials (titles in italics) may serve to illustrate the point:

Government Medicine? Sure! "There *is* a place for government in medicine. We have seen the useful work done by the Public Health Service. We have w[illegible] he success of the Veterans' [illegible]nation home-town-care program. Many of us favor expanded aid for the medically indigent . . . Government medicine? Sure! Just show people where to draw the line."

Fee Control Coming: "What fraction of our profession charges indefensibly high fees? Estimates range from 'the iniquitous 1 per cent' to 'about 15 per cent of our numbers' . . . There's no longer much question about *whether* excessive fees will be controlled. It's mainly a question of *who* will do the controlling: medicine or the Government. If we're smart, we'll beat Uncle Sam to the punch."

Is Your Prosperity Showing? "This is not to suggest that the medical man shouldn't enjoy the fruits of his labors. It *is* to suggest a bit more restraint in the public demonstration of his earning power . . . How long, we wonder, will a fringe of physicians go on strengthening the socializer's hand by unwitting displays of their current good fortune?"

• • •

Such editorials cut through controversies or, sometimes, start them. They're not written to produce universal agreement—not when the subjects range from osteopathy (last month) to Eisenhower (this month). They *are* written to stimulate constructive thought and action. And twenty-nine years' worth of incoming mail seems to testify that they do.

—LANSING CHAPMAN

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